Constructing infertility in Malawi:

Management of interpersonal, normative and moral issues in talk

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Declaration

I, Bregje Christina de Kok, declare that this thesis has been composed by me and that this is my own work, except as specified. I further declare that this work has not been submitted for any other degree or professional qualification.

Date: _____ **Signature:** _____

Abstract

This study examines social constructions of infertility in Malawi. The literature on infertility consists of epidemiological studies, describing patterns of infertility in terms of its incidence, causes and health seeking behaviour; studies of the psychological correlates of infertility; and ethnographic studies which describe experiences, perceptions and management of infertility within specific socio-cultural contexts. In addition, some studies discuss social aspects of medical practice in relation to infertility. Overall, studies of infertility in developing countries emphasize its many serious psychological and social consequences, usually attributed to cultural norms mandating parenthood. There appear to be several lacunae in the literature: men with fertility problems are rarely included, an in-depth examination of practitioners' views is missing, and no qualitative study has been conducted on infertility in Malawi, which has a considerable secondary infertility rate. Furthermore, although ethnographic studies highlight the interpersonal (related to others' judgements), normative (related to ideas about what 'ought' to be) and moral (related to ideas about what is good or bad) issues involved in infertility, no study has investigated how these issues are managed *in situ*, in verbal interactions. However, it has been argued that 'talk' is a prime site for the management of issues such as blaming and deflecting responsibility. Hence, this study addresses several gaps in the literature. It focuses on Malawi, and includes a wide range of participants: women and men with a fertility problem, significant others, indigenous and (Malawian and expatriate) biomedical practitioners. Semi-structured interviews with 63 participants were recorded and transcribed, and translations were obtained of interviews in which interpreters were used. For the analysis, I used discourse analysis (DA), informed by conversation analysis (CA). This analytic approach, novel in infertility studies, examines the interpersonal functions of statements in interactions, such as blaming or justifying.

Use of DA and CA has led to novel insights into how respondents construct infertility, its causes, solutions (sought and offered), and consequences, and how they thereby manage interpersonal, normative, and moral issues, revolving around accountability, blame and justification, and attribution of (problematic) identity categories. For instance, I have shown how respondents construct childbearing as a cultural, normative requirement, and how this can be used to justify practices like extramarital affairs, or polygamy, as necessary solutions. In addition, identifying causes appears to be problematic for people with a fertility problem due to certain interpersonal and interactional issues, such as the idea that they are not entitled to

medical knowledge. Practitioners can be seen to work up and bolster an identity of professional, competent expert in constructions of causes of infertility, and by attributing problems in helping infertility clients to external factors, including patients' intelligence.

This study has several theoretical, practical, and methodological implications, although I discuss some thorny methodological issues, especially those concerning the use of translations and the transferability of the analytic findings. A first contribution pertains to methodological debates and developments in conversation analysis, and in studies of infertility and other health issues which rely upon people's self-reports. Second, my study contributes to theoretical developments in health psychology and health promotion. My analysis points to the relevance of social and normative considerations for engagement in 'risky' behaviours, such as extramarital affairs. This challenges cognition models which treat health behaviour as the outcome of individualistic decision-making processes, and see providing information as the main way of changing people's behaviour. Therefore, a third set of implications is of a practical nature: some of the findings can contribute to health promotion, as well as to improvement of health services. For example, practitioners' attribution of failures and (communication) problems to their patients, may prevent them from reflecting critically on, and addressing, their own contributions to problems. Overall, this thesis shows that when one wants to 'give voice' to people who are suffering from infertility, it is valuable to examine what they say in detail, within its interactional context, and the concerns they themselves make relevant, in their own terms.

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‘Not everything that can be counted counts, and not everything that counts can be counted.’ (Albert Einstein, attributed)

‘Only when such a researcher moves beyond the gaze of the tourist, bemused with a sense of bizarre cultural practices (‘Goodness, you do things differently here!’) do the interesting analytic questions begin’ (Silverman, 1993, p.289)

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Chapter 1. Introduction

In this thesis, I examine social constructions of infertility, its causes, solutions and consequences, in Malawi. This means that I aim to gain an understanding of how various people in Malawi *create* realities regarding infertility in interactions (cf. Berger & Luckmann, 1966; cf. Burr, 1995; cf. Gergen, 1999), rather than of *what* the causes and consequences of and solutions for infertility 'really', 'in essence' are. 'Various people' include women and men with a fertility problem, significant others of people with fertility problems and (biomedical and indigenous) health practitioners. Perhaps counterintuitively**,** infertility is a significant public health problem in developing countries, particularly in sub Saharan Africa, and has been found to have many social and psychological consequences for people suffering from it. It is therefore in dire need of policymakers', health practitioners' and researchers' attention.

I will focus specifically on how people construct infertility, its causes, consequences and solutions in (interview) talk. This is important, as verbal interaction appears to be the prime site for the management of interpersonal, moral and normative issues (Bergmann, 1998; Drew, 1998; Linell & Rommetveit, 1998), which various studies show to be central to the problem of infertility in developing countries. People without, or with few, children are seen as deviating from cultural norms to bear children, they are stigmatised and blamed, and their relationships at both a community, family and conjugal level are affected (van Balen & Inhorn, 2002; Gerrits, Boonmongkon, Feresu & Halperin, 1999; Inhorn, 1994).

In order to analyse constructions of infertility in talk, I use discourse analysis, informed by conversation analysis. This form of analysis has not been used before in infertility studies. As a result, my PhD study leads to innovative insights, which can contribute to the understanding and alleviation of the burden of infertility in developing countries like Malawi. In section 1.1, I will discuss in more detail why infertility is a problem in sub Saharan Africa and Malawi, and how my doctoral research can contribute to the development of reproductive health programs and services for infertility. In section 1.2, I will provide an overview of the chapters in this thesis.

1.1 Infertility in Malawi

Infertility is commonly defined as the inability to conceive after exposure to conception for a period of between one and two years (WHO, 1975). Often, the criterion of inability to conceive is replaced by the criterion of absence of 'fertile pregnancy', i.e. a pregnancy resulting in a live birth (cf. Leonard, 2002). Demographers usually use a longer period of five to seven years in their definition of infertility. Normally, a distinction is made between primary infertility, when a woman has never conceived or given birth to a live child, and secondary infertility, when a woman has given birth at least once, and subsequently becomes infertile (WHO, 1975).

An increasing number of studies report that, for several reasons, infertility is a serious problem in the developing world in general, and in sub Saharan Africa in particular. First, it has been found that infertility has many serious psychological and especially social consequences for people in developing countries. It appears that men, and especially women, with fertility problems are often stigmatised and ostracised in their communities, and pressurized by their family to solve their fertility problems and give birth (Gerrits et al., 1997; Inhorn, 1994; van Balen & Inhorn, 2002).

Second, in sub Saharan Africa, infertility is intertwined with other serious public health problems, like sexually transmitted diseases (STDs), and the Human Immunodeficiency Virus or acquired immunodeficiency syndrome (HIV/AIDS). STDs are one of the main causes of infertility in sub-Saharan Africa (Ericksen & Brunette, 1996, Inhorn, 1994). At the same time, infertility appears to be one of the factors which contributes to the spread of STDs, including AIDS. This is so because infertility often leads to marital instability and increase in number of sexual partners (van Balen & Inhorn, 2002; Favot, Ngaluka, Mgalla, Klokke, Glumodoka, & Boerma, 1997). In addition, studies in several African countries have found that some people fear that using contraceptives, including condoms, can lead to infertility, which makes people reluctant to use them (Upton, 2001; Feldman-

Savelsberg, 1994; Gerrits et al., 1999). Therefore, fears of becoming infertile can put people at risk for STDs and AIDS, as well as impede family planning.

Third, infertility is a matter of considerable relevance to public health because infertility clients can place a large demand on the limited health care resources in sub Saharan Africa (Leonard, 2002; PATH, 1997). It has been observed that people with fertility problems often seek solutions relentlessly, from various sources, including biomedical health services (Rowe, 1999; Sundby, 2002). In a hospital in Cape Town, it was found that the average number of consultations of infertility couples was seven, with over 20% of couples having had between 11 and 40 consultations (Rowe, 1999). In some African countries, it has been reported that one third of gynaecological consultations pertains to infertility cases (Rowe, 1999). Okonofua (1996) even found that in Nigeria, infertility is the main reason for gynaecological consultations. The high numbers of infertility consultations are unfortunate, especially as the medical possibilities to solve fertility problems are very limited in sub Saharan Africa (Leonard, 2002; Rowe, 1999; Sundby, 2002). Thus, it appears that the large numbers of medical consultations for infertility are expensive, time consuming and often frustrating for both practitioners and people suffering from fertility problems.

Infertility can be expected to be an important public health problem in Malawi as well. Malawi is one of poorest countries in the world, and has a very low rank order of 165 out of 177 on the Human Development Index (UNDP, 2005) [1]. It has a primary infertility rate of 2%, and a much higher secondary infertility rate of 17% of couples between 20 and 44 years old (Larsen & Raggers, 2001). This rate is considerable and falls in the upper middle range of infertility rates in sub Saharan Africa, which range from 5% to 23% (Barden-O'Fallon, 2005). The 2002 Reproductive Health Policy of Malawi acknowledges the seriousness of fertility problems, the demand for infertility services, and the importance of preventing and treating this health problem (personal communication, Len Verhoeven, 2003).

It is to be expected that also in Malawi, there is a strong mutual relationship between infertility and STDs and especially HIV/AIDS, where incidence of STDs

[1] The Human Development Index combines several indicators of development, such as life expectancy (39.7 in Malawi, vs. 46.1 in sub Saharan Africa), literacy rate (64% of population older than 15 years, vs. 60.5 % in sub Saharan Africa), and GDP per capita ($605, vs. $1856 in sub Saharan Africa).

and particularly HIV are high (Daly, Franco, Chilongozi & Dallabetta, 1998). Malawi's HIV incidence is 14.4%, varying from 4% to 36%, dependent on geographical area, gender and age category (Family Health International, 2002). Highest rates have been found amongst young women between 15 and 24 years. A significant number of women who engage in extramarital sexual relationships because their own or their male partner's marriage remains childless, can be expected to be fall in this age category.

Frequent consultations by infertility patients will form a considerable burden on Malawi's health care system, which is said to suffer from 'an acute human resources crisis' (Grant & Logie, 2005, p.7). In governmental hospitals, which form 65% of Malawi's health services[2], a mere 1.6 physicians, and 28.6 nurses are working per 100.000 inhabitants[3] and 10 gynaecologists for its 12 million inhabitants (Grant & Logie, 2005). Not only is the quantity of Malawi's biomedical health services limited, but also the quality. In their report for the Scottish Executive, Grant & Logie (2005, p.7) describe health services in Malawi as 'suffering from lack of drugs, poor staff-client relations, and poor quality diagnosis and treatment and even a lack of lighting'. Thus, it is likely that infertility consultations in Malawi are often frustrating, and, literally, fruitless, for both providers and couples suffering from fertility problems.

In sub-Saharan African countries[4], including Malawi, infertility has not received the attention from researchers and policymakers which it requires, considering its highly problematic nature (Dyer, Abrahams, Hoffman, van der Spuy, 2002; Berer, 1999; Gerrits, 1997; Upton, 2001). This neglect has been attributed to the tendency to associate Africa with a problematic *surplus* of fertility, rather than with fertility problems (Dyer *et al.*, 2002; Upton, 2001; van Balen & Inhorn, 2002). Women's health activists have criticised reproductive health programs for their

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[2] 35% of the health services in Malawi is provided by the Christian Health Association of Malawi (CHAM). I could not obtain official figures about numbers of practitioners working in these mission hospitals, although through personal communication I was informed that there is only one gynaecologist working in CHAM hospitals (S.Makin, 18th of March, 2006). Grant and Logie (2005) restrict themselves as well to the governmental health services.

[3] This number is low in comparison to other African countries: Tanzania for example has 4.2 physicians and 85.2 nurses per 100.000 inhabitants, South Africa respectively 25.1 and 140.

[4] In developing countries in South America and Asia, more therapeutic possibilities have been made available, such as assisted reproductive technologies (in particular IVF), although this involves its own problems (see Bharadwaj, 2002; Inhorn, 2005).

narrow focus on peri-natal services and birth control, and their attention to the needs of a limited range of women: those who fall in the 'reproductive age' categories and are, moreover, fertile (Gerrits et al, 1999). In 1994, at the United Nations' International Conference on Population and Development (ICDP), infertility was put on the international reproductive health agenda for the first time (Gerrits et al., 1999; van Balen & Inhorn, 2002). The ICDP's *Program of Action* acknowledges that infertility is one of the factors affecting reproductive health, and calls for an increase in the scope of reproductive health services by incorporating treatment and prevention of infertility (UNFPA, 1994). However, as Sundby (2002) states, in Africa, the aim of adequate, comprehensive reproductive health care services has not yet been achieved.

Nevertheless, both the ICDP's program of action and various scholars have pointed the way forward, and have highlighted requirements which adequate, comprehensive reproductive health programs and services for infertility and other issues ought to meet. First, programs and services should be based on the interests, needs and rights of individuals, rather than on the aim of achieving population targets (Gerrits et al., 1999; Tremayne, 2001; UNFPA, 1994, Upton, 2002). Second, they should be culturally sensitive. This means that reproductive health programs should take into account the socio-cultural context which informs reproductive health problems, needs, and behaviours (UNFPA, 1994). Therefore, in order to be culturally sensitive, reproductive health services and programs ought to be based on *local* perceptions, experiences and explanations (UNFPA, 1994; Walraven 2001; Dyer et al., 2002; Feldman-Savelsberg, 1994, Gerrits et al., 1999, Harrison & Montgomery, 2001; Tremayne, 2001; Upton, 2001).

Therefore, there is a need for research on reproductive health issues in general, and infertility in particular, which can provide insights into people's needs, and their own views and understandings, and thereby inform the development of reproductive health programs (cf. UNFPA, 1994). My doctoral research on social constructions of infertility in Malawi seems particularly well placed to address this need, for several methodological reasons.

First of all, I use a definition of infertility to which people's own understandings are central. Several scholars have pointed out that standard western,

academic definitions of infertility, described above, are not necessarily meaningful for people in developing countries (Gerrits et al, 1997; Leonard, 2002). For instance, as pregnancy is often expected within months of marriage, people can have a fertility problem long before they would 'count' as infertile according to official definitions and statistics. In addition, infertility studies often focus on married women, whereas *unmarried* women may also experience fertility problems, especially considering that fertility problems often result in divorce (Gerrits et al., 1997; Leonard, 2002). Therefore, for the purposes of my study, I consider women or men as having a fertility problem when *they consider themselves, or are seen by others as, having fertility problems*, regardless of duration, number of children or marital status. Note that whereas authors like Gerrits (1997) and Meera Guntupalli and Chenchelgudem (2004) have also based their definition of infertility on people's own views, I include the views of others as well, as these can be expected to matter for categorisations of people as infertile.

Second, my study uses a qualitative methodology, which appears ideal for gaining insight into local views and explanations. Indeed, several authors have identified a need for *qualitative* research on reproductive health issues like infertility (Dyer, 2002; Harrison & Montgomery, 2001; Mbizvo & Bassett, 1994). The open, 'bottom up' rather than 'top down' nature of qualitative research enables the exploration of issues, which one cannot predict on the basis of one's cultural or academic framework (Willig, 2000). In addition, as Obermeyer (2005) argues, qualitative studies are particularly apt for providing insight into variable, *contextualised* meanings of behaviours.

Third, I use the qualitative methodology of discourse analysis (DA, Potter & Wetherell, 1987), informed by conversation analysis (CA, Sacks, 1992). Characteristic for this particular qualitative method of analysis is a commitment to basing analytic claims on *participants'* displayed understandings and concerns, rather than on pre-conceived analytic ideas and concepts. This will be discussed further in chapter 3. In addition, the literature (see chapter 2) suggests that infertility is intertwined with various interpersonal, normative and moral issues. As I will explain in chapter 3, DA and CA are particularly appropriate tools for gaining insight

into the situated, interactional management of interpersonal, normative and moral issues, such as blame and accountability, in talk about infertility.

1.2 Overview of the thesis

In chapter 2, I review the relevant literature. I discuss four categories of infertility studies: large scale epidemiological and demographic studies, quantitative studies of psychological correlates of infertility, ethnographic studies of local perceptions and experiences of infertility and studies of biomedical practice in relation to infertility. As I will show, these studies demonstrate that infertility is a serious personal, social and public health problem, and draw attention to the interpersonal, moral and normative dimension of infertility and medical practices related to infertility. However, overall, the studies of infertility are restricted in their range of participants, little attention has been paid to Malawi, and none of these studies has used discourse analysis or conversation analysis to examine talk about infertility in its interactional context.

In chapter 3, I discuss the methodology of the study. I describe the particular kind of discourse analysis which I use, and explain how it incorporates conversation analytic and ethnomethodological principles. In addition, I show how conversation and discourse analysis has been used before to examine the management of morality and normativity in talk. I subsequently describe the method of data collection, including sampling and recruitment strategies, the participants and interview process, and describe the process of analysis. I conclude the chapter with a discussion of methodological issues related to the use of interview data, at times mediated by an interpreter, in which the participants are non-native speakers, and belong to a different socio-cultural community than the analyst.

In chapter 4, I begin my discursive analysis of the normative and moral dimensions of infertility, by discussing how men and women with a fertility problem, significant others, and health care practitioners, construct infertility as a problematic deviation from normative expectations. In the literature on infertility in developing countries, references to norms of childbearing are common. However, no one has examined how cultural norms are actively constructed *in situ*. This leads to valuable new insights into how the construction of a cultural norm of childbearing can fulfil

an interactional, rhetorical function: I show how respondents use it to justify certain practices, like engaging in extramarital affairs when no children are born. This analytic finding resonates with Parsons' (1951) ideas that illness is a deviant state for which people ought to find a solution. In my interview data, respondents construct infertility as deviation from the norm, which therefore *ought* to be solved, for example by engaging in extramarital affairs.

Many scholars have paid attention to what people perceive to be the causes of health problems, partly because they are seen as informing people's health seeking behaviour. In chapter 5, I examine *how* men and women with a fertility problem talk about and construct causes of infertility, rather than taking stock of *what* causes are put forward. This brings to the light certain interactional and interpersonal issues involved in talking about causes. For example, displays of knowledge about causes appear to be informed by normative expectations about who has an entitlement to medical knowledge and by the potential problem that undesirable conclusions are drawn about respondents' personal experience with sensitive issues like STDs and abortions. The interpersonal, normative and moral issues involved in making knowledge claims, problematizes the idea that verbal statements provide access to people's individualistic or collective illness cognitions, as well as the link between illness cognitions and illness behaviours.

In order to develop a more social understanding of people's illness behaviour, I focus in chapter 6 on how men and women with a fertility problem talk about the actions they took to solve their fertility problem, and especially about not seeking help (anymore). I will show that respondents emphasize the effort they put into seeking a solution, treat not seeking help as accountable, and provide warrants for not seeking help which draw upon factors which lie outside their responsibility. Again, these findings are in accordance with Parsons (1951) idea of 'the sick role' as involving an obligation to seek competent help. McHugh (1979) argues that being labelled as deviant depends partly on the assessment that other (non-deviant) actions *could* have been taken. These ideas suggest that demonstrating that one has tried to seek help but was 'forced' not to take action (anymore), is a way for men and women with a fertility problem to play down their culpability for not seeking help. Thus, also

accounts about illness behaviour point at the moral and normative nature of infertility and its management.

Considering that infertility appears to raise various interpersonal issues, it seems appropriate to look at how relationships between people with a fertility problem and their spouses, significant others and other people in the wider community are constructed. This is the theme of chapter 7. The literature frequently reports that infertility has negative consequences for people's relationships. Surprisingly, it appears that in my data, men and women with a fertility problem and significant others regularly construct their relationships as good. If respondents do discuss problems, they tend to avoid blaming others or being blamed. This can be understood as a response to interpersonal and interactional delicacies which talk about problems, complaining and blaming involves, as several conversation analysts have pointed out (Bergmann, 1998; Linell & Rommetveit, 1998). These findings suggest that scholars' characterisations of relationships of people with a fertility problem as marked by social exclusion, stigmatisation and abandonment gloss over the unproblematizing, mitigation and blame avoidance which respondents may attend to when talking about their relationships.

In chapters 8 and 9, I shift the analytical gaze to the interpersonal, normative and moral issues at stake for health practitioners, both traditional healers and biomedical practitioners. In chapter 8, I examine the rhetorical design of health practitioners' claims about causes of infertility. I will show how practitioners deal with their accountability for their claims, for instance by making relevant category attributes associated with scientific experts, such as testing and reading literature. I argue that in so doing, they bolster an identity of health expert. In addition, I will discuss how, when asked about non-biomedical causes, Malawian and western biomedical practitioners juggle an identity project of biomedical expert with other interpersonal demands, like not coming across as ethnocentric or being a proper cultural member. I will point out that these findings show how both biomedical and

indigenous knowledge and practices are of a fundamental social, that is interpersonal, nature, rather than the (application of) neutral scientific 'textbook' knowledge or (distorted) socio-cultural beliefs.

Successes, failures and problems in health care are central to practitioners' perceived competence. In chapter 9, I examine how biomedical practitioners and traditional healers account for successes and failures in helping infertility patients. I show that whilst respondents attribute success to their own actions, they mitigate their accountability for problems. I argue that in this way, respondents can bolster their competence. This chapter then, suggests that interpersonal issues like upholding professional competence inform practitioners' accounts about successes, failures and problems in helping infertility patients. Hence, both chapters 8 and 9 show how accounts of *both* biomedical practitioners and indigenous healers are worth investigating for the interactional, interpersonal and moral work they perform.

In chapter 10, I summarize the main findings, discuss several methodological issues which this study raises, related in particular to the use of (translated) interpreter-mediated interviews, and evaluate the quality of the analysis. Thereby I address the generalizability of the analytic findings. Thereafter, I discuss how this study makes various contributions; to the (infertility) literature, methodological developments and debates, theoretical developments in health psychology and health promotion, and practical attempts to alleviate the burden of infertility through health promotion and improving the quality of (reproductive) health services. I conclude with suggesting that in future research, discourse analysis and conversation analysis could be used to study other important (reproductive) health problems in developing countries to which moral and normative issues seem pertinent, such as abortions, miscarriages and maternal mortality.

Chapter 2. The literature on infertility

In this chapter, I review the literature on infertility, focussing where possible[5] on studies of infertility in the developing world. I will discuss four categories of infertility studies[6,7]. I derived these categories by comparing and contrasting papers on infertility in terms of the reported studies' aims, the themes they address, and methodology used, including the level of analysis (i.e. individuals, collectives, or individuals-in-context). From this, four clusters of studies emerged which could reasonably be grouped together: epidemiological studies, studies of psychological correlates of infertility, ethnographic studies and studies of the social nature of biomedical practice in relation to infertility

I will first discuss epidemiological studies of infertility, which have described patterns of infertility in various nations, in terms of its incidence, causal correlates and health seeking behaviour, that is behaviour aimed at the promotion of health, or in this case, fertility (cf. MacKian, 2003) (section 2.1). These studies do not provide insight into what infertility means for people. A second category provides some insight into this, by studying the relationship between infertility and various psychological factors (section 2.2). These studies ignore the social situation in which infertility is experienced and dealt with, unlike a third category of infertility studies (section 2.3), which describe local experiences, perceptions and management of infertility, in relation to the socio-cultural context. Some of these, mainly qualitative and ethnographic studies include descriptions of biomedical and indigenous practices in relation to infertility. These studies are most similar and therefore most relevant to my work. They highlight the social, normative and moral nature of infertility, but most do not address the social aspects of medical practices. This is the central theme of the fourth category of infertility studies which I will discuss (section 2.4), which tend to focus on work of biomedical practitioners who work in western IVF clinics.

[5] As will become clear, some types of infertility studies focus virtually exclusively on the west.
[6] These categories are necessarily 'ideal types', in that they are based on a selection of characteristics common to most studies in the category.
[7] This review is necessarily selective. I will not discuss studies of assisted reproductive technologies (ART) in the developing world (see e.g. Bharawadj, 2002; Inhorn, 2002), as possibilities for ART are limited in sub Saharan Africa, and absent in Malawi.

In section 2.5, I will identify several omissions in the literature. In particular, scant attention has been paid to certain social actors and to social aspects of medical practices regarding infertility in non-western countries, and no qualitative study has been conducted in Malawi. Furthermore, no study has looked in detail at how people talk about infertility, and the context of infertility has either been ignored, or addressed only in terms of the macro, cultural, context. As I will argue, my study of how Malawian people construct infertility in talk addresses these lacunae.

2.1 Epidemiological and demographic studies: Patterns of infertility

A first category of infertility studies which I want to discuss are studies which compare and describe patterns of infertility in various parts of the world, especially in terms of its incidence, causal correlates, and people's health seeking behaviour. These studies are based on large scale quantitative surveys, at times combined with medical investigations (e.g. Barden-O'Fallon, 2005; Cates, Farley and Rowe, 1985; Favot, Ngalula, Ngalla, Klokke, Gumodoka & Boerma, 1997). Data collected are analysed using descriptive and inferential statistics, like logistic regression analysis[8]. Frequently cited papers in this category of infertility studies are Ericksen and Brunette's (1996) and Cates, Farley and Rowe's (1985). Ericksen and Brunette's (1996) study is a comparison of Demographic Health Surveys (DHS) and World Fertility Survey (WFS) data from the 1980s of 27 African nations. Cates et al.'s (1985) paper is based on an international WHO study of infertility clients in clinics in developing and developed countries, on all continents. Although by now, both papers and the data on which they are based are relatively old, and thus possibly outdated, both papers are still widely quoted.

2.1.1 Incidence of infertility

The epidemiological and demographic studies demonstrate that infertility rates are considerable in sub Saharan Africa. Ericksen and Brunette (1996) calculated the percentages of women, between 20 and 41 years, who have been exposed to

[8] For more information regarding methodological features, see table 2 in the appendix

conception but have not given birth for a period of at least 5 to 7 years[9]. Excluded were women who use contraception, or had never had sex, or had not been menstruating for 5 years. As table 1 shows, Ericksen and Brunette (1996) found that overall, primary infertility rates are low across Africa: most rates are below 4%. According to Ericksen and Brunette (1996), Malawi has a primary infertility rate of 1.1%. More recently, Larsen (2000), using a similar definition of infertility, reports a slightly higher primary infertility rate in Malawi of 2%.

Table 1.
Selection of infertility rates in African nations, from Ericksen and Brunette (1996)

Nation	Infertility Range (%)	Midpoint (%)	Primary infertility (%)
Burundi	8.6-11.5	10.5	1.3
Ghana	10.1-13.5	11.8	1.6
Sudan	10.6-14.0	12.3	3.1
Nigeria	10.5-14.6	12.6	4.0
Cote d'Ivoire	11.5-14.8	13.2	5.0
Malawi	**12.2-15.0**	**13.6**	**1.1**
Kenya	13.7-16.7	15.2	2.7
Zambia	13.8-17.5	15.7	1.4
Botswana	14.9-21.0	18.0	3.6
Zimbabwe	16.8-22.4	19.6	2.8
Lesotho	17.1-21.5	19.3	4.0
Sub-Saharan average	12.5-16.0	14.5	

However, secondary infertility is much more common than primary infertility in Africa, unlike in other parts of the world where primary infertility rates appear higher (Cates et al., 1985). According to Ericksen and Brunette (1996), combined primary and secondary infertility rates vary between African nations from 8.6% to 22.4 % of women between 20 and 41 years old. They found that Southern Africa has the highest incidence of infertility, although others argue that they are highest in Central

[9] Ericksen and Brunette (1996) calculated infertility rates for both the criterion of 5 and 7 years, and then calculate the midpoint.

Africa, also called 'the infertility belt' (Collet, Reniers, Frost, Gass, Yvent, Leclerc, Roth-Meyer, Ivanoff & Meheus, 1988).[10]

In Malawi, Ericksen and Brunette (1996) found an incidence rate between 12.2% and 15%, with a midpoint of 13.6%, whilst Larsen (2000) reports a somewhat higher secondary infertility rate of 17%. Ericksen and Brunette (1996) point out that the total number of women suffering from infertility during some period in their lives, is higher than these infertility rates suggest. Their survey points out that a significant proportion of currently fertile women had infertile, childless intervals for a period of 5 to 7 years in previous periods in their lives. In Malawi, this was the case for 15.8% of currently fertile women.

2.1.2 Causes of infertility

Epidemiological studies show that the most common cause of infertility in Africa appears to be infections, leading to pelvic inflammatory disease (PID) (Cates et al, 1985; Larsen, 1995; Sundby, 1997). PID can cause infertility when it results in blocked fallopian tubes, pelvic adhesions (Cates et al., 1985) or ectopic pregnancies (Bhatti & Fikree, 2002). Cates et al. (1985) report that in their study, in over 85% of infertility cases in Africa, the diagnosis was related to infections, in comparison to 36% in the developed world.

The infections responsible for PID can be related to unsafe, unhygienic pregnancies and abortions (Cates et al., 1985; Ericksen and Brunette, 1996; Larsen, 1995; Sundby, 1997) and STDs (Cates et al., 1985; Collet et al., 1988; Samucidine, Barreto, Lind, Mondlane & Bergstrom, 1999), especially HIV/Aids (Favot et al, 1997), and gonorrhoea and chlamydia (Ericksen & Brunette, 1996). Syphilis can lead to infertility as well, by causing miscarriages or stillbirths (Cates et al., 1985; Larsen, 1995).

It should be noted that findings regarding the relationship between STDs and infertility are somewhat ambiguous. According to Ericksen and Brunette (1996), 70% of PID cases in Africa is due to STDs, especially gonorrhoea and chlamydia. However, Barden-O'Fallon (2005) and Favot et al. (1997) found that STDs were not

[10] Therefore, when authors speak about the 'infertility belt' of Africa, they sometimes refer to Central Africa, sometimes to both Central and Southern Africa (see e.g. van Balen & Inhorn, 2002).

significantly associated with infertility, in respectively Malawi and Tanzania. In addition, although Barden-O'Fallon (2005) found an association between self-reported infertility and HIV positivity in Malawi, the relation was not significant. However, they point out that a rather large percentage of participants did not want to be tested for HIV (20% of women, 33% of men). As this group was included in the group with negative HIV test results, which was compared with those who tested positively, this may have diluted the findings.

Despite some ambiguity in the findings of epidemiological studies, STDs including HIV are normally seen as one of the main causes of infertility in the developing world. Other factors which are thought to lead to infertility in Africa, although mentioned less often, are malaria, as it can cause miscarriage (Larsen, 1995), malnutrition (Sundby, 1997), female circumcision (Gerrits, 1997; Sundby, 1997, Larsen, 1995), the insertion of intrauterine devices (IUD) (Gerrits et al., 1999) and cervical cancer (Gerrits et al., 1999).

The factors discussed so far pertain mainly to women. Factors leading to male infertility are discussed much less in the literature on infertility in the developing world. This can partly be attributed to the fact that many studies focus on women only. The medical literature on infertility in general identifies various reasons for male infertility, related to problems of the sperm (e.g. not enough sperms, low sperm motility), the seminal fluid (e.g. containing pus) or blocked ejaculatory seminal duct (McConell, 1993, Wood, 1994). These problems can be either congenital or caused by environmental factors, like infections (Dunitz, 1993). Cates et al. (1985) found that in Africa, main causes of infertility in men were varicocele, enlarged veins in the scrotum (20%), and accessory gland infection (11%). Both causes were more common in infertile men in Africa than in other parts of the world. Inhorn (2003) points out that psychosexual dysfunctions, like premature ejaculation or impotence can also contribute to fertility problems.

Epidemiological and demographic studies have identified several more distal causes, that is, behavioural correlates of infertility. Examples of these are being sexually active at an early age, usually defined as below 13 years (Ericksen & Brunette, 1996, Larsen, 1995), and having had a relatively large number of sexual partners (Barden-O'Fallon, 2005; Favot et al., 1997; Ericksen & Brunette, 1996).

Barden-O'Fallon (2005) found that in Malawi, having exchanged money or goods for sex was associated with fertility problems in men, but not in women. They note that this is an important gender difference, but do not attempt to explain it.

Furthermore, demographic factors which have been found to correlate with infertility are being in a polygamous marriage (Barden-O'Fallon, 2005), being or having been divorced (Ericksen & Brunette, 1996, Favot et al., 1997; Larsen, 1995) and urban, rather than rural residence (Ericksen & Brunette, 1996, Larsen, 1995). In addition, Ericksen and Brunette (1996) find a relationship between ethnicity and infertility in various African nations, with some ethnic groups within the same nation having higher infertility rates than others.

The relationship between socio-economic class and infertility has been examined as well, but findings are equivocal. Larsen (1995) reports that in Cameroon and Nigeria, socio-economic class, education and occupation are not significantly related to infertility. By contrast, Barden-O'Fallon (2005) found that in Malawi, being in the highest income group is significantly associated with infertility, but only in men.

It is worth noting that correlational data do not allow determination of the direction of the associations between infertility and the various related factors. Thus, STD and HIV can both be the *causes* of infertility, and the *result* of an infertile status, for example because people with fertility problems may engage in more 'unsafe' sexual relationships, in an attempt to bear children. In addition, being sexually active from a young age, having more sexual relationships, polygamy and divorce can be seen as risk factors of STDs and HIV/AIDS (cf. Ericksen & Brunette, 1996), and may therefore increase the chance of becoming infertile. However, with the exception of being sexually active at a young age, these characteristics can also be a result of an infertile condition.

2.1.3 Health seeking behaviour

In addition to patterns in incidence and causes, some studies have examined patterns in people's health seeking behaviour for infertility, that is, the actions taken to solve a fertility problem. They show that people in Africa frequently seek help for infertility. Barden-O'Fallon (2005) and Walraven et al. (2001) found that slightly

less than 60% sought biomedical or indigenous treatment for fertility problems. Walraven et al. (2001) found in their study of reproductive illness in the Gambia that this percentage is higher than for any other reproductive health problem.

Cates et al. (1985) found that, like incidence and causes, also patterns of health seeking behaviour are different in Africa than in other regions of the world. Women in Africa appear to use infertility services when they are relatively young: 42% of the women in the study by Cates et al. (19985) who sought biomedical care in Africa were below 24 years, compared to 25% in the developed countries. At the same time, Cates et al. (1985) found that women in Africa had waited significantly longer before seeking biomedical health services than women in the developed world. In Africa, 33% had waited for more than 2.5 years, whereas in the developed world, 50% had waited less than 2 years (Cates et al., 1985). Hence, it appears that for women in Africa infertility problems become apparent at a relative young age.

Cates et al. (1985) found that, unlike women, men in Africa who sought biomedical care tended to be older than men in other parts of the world. Barden-O'Fallon (2005) found that in Malawi, women consult biomedical practitioners more often than men. These findings seem to indicate that men are less eager than women to seek biomedical services, especially when they are younger.

Several studies indicate that people consult indigenous healers more frequently than biomedical practitioners (Barden-O'Fallon, 2005; Favot et al., 1997; Walraven et al., 2001). Barden-O'Fallon (2005) for example found that in Malawi, 74.7% of all women in their survey who had made use of some form of health care, had consulted indigenous healers, and 80% of all men who had sought help from health services. It appears that when people consult healers, they do so frequently: in the study by Favot et al (1997), infertile women reported on average 5.9 visits to indigenous healers, and 1.7 visits to western health services.

Regarding demographic factors associated with use of health services, Barden- O'Fallon (2005) found a significant positive association between being educated and seeking biomedical or indigenous treatment in Malawian women with fertility impairments. However, this association was not found in men: for them having *no* education was related to seeking help. Thus, like the association between

education and infertility, the relation between education and use of health services is unclear.

2.1.4 Conclusion

Large scale, survey based studies, of demographic or epidemiological nature, show that the incidence of secondary infertility is high in sub Saharan African countries, affecting in Malawi 17% of couples between 20 and 44 years. Considerably more couples are affected by fertility problems if one includes all infertile periods in people's lives. In addition, they have identified infections as the main causes of infertility infections, related to pregnancy and abortion complications, and STDs, including HIV/AIDS, which lead to pelvic inflammatory disease. Furthermore, several behavioural and demographic factors appear to correlate with infertility, like being sexually active at an early age, having many sexual relationships, being divorced or being in a polygamous marriage, and living in town. Use of biomedical and especially indigenous care for infertility appears to be common.

These epidemiological and demographic studies are thus useful for the identification of patterns in infertility, and can sketch the 'profile' of the 'average' infertile person in African countries. However, they are limited in their possibilities to provide insight into underlying social or psychological mechanisms which can *explain* observed patterns. Ericksen and Brunette (1996, p.217) acknowledge this in relation to the ethnic variation of infertility rates which they observe. They point out that ethnic variation cannot be accounted for by the factors in their regression model, and suggest that there are therefore 'cultural-specific influences' which would have to be further investigated in demographic *and* non-demographic studies. Ericksen and Brunette (1996) suggest studies of a historical and ethnographic nature.

Epidemiological and demographic studies are limited in their ability to explain patterns in infertility, partly because there is little room in these studies for local views and meanings, which can be expected to be important for people's actions. The reliance on 'etic' academic perspectives and conceptualisations in epidemiological and demographic studies is apparent for instance from the definitions of infertility which they use. Infertility is usually defined as failure to conceive during a period of between 5 and 7 years, or sometimes 1 year, of

unprotected intercourse. Many authors have pointed out that such definitions are of little meaning in non-western settings, as people will be considered to have a fertility problem long before 5 to 7 years have passed (Gerrits et al., 1999; Leonard, 2002; Sundby, 2002)[11]. In addition, the use of quantitative survey methodologies, in which responses are transposed into a limited number of pre-established categories, prevents gaining insight into issues as deemed relevant by people themselves.

2. 2 Studies of psychological correlates of infertility

A significant number of studies focus on the meaning which infertility has for people, in that they examine whether and to what extent infertility is associated with certain psychological states and processes. The main domains of investigation in these studies are psychological correlates of infertility and its treatment, such as depression, anxiety, and marital (dis)satisfaction, the mediating effect of factors such as gender, coping style and cognitions, and decision making regarding solutions and treatment.

Studies of psychological correlates use predominantly quantitative methodologies, either questionnaires, structured interviews or, most commonly, pre-existing, standardized psychometric tests (see table 3 in the Appendix)[12]. Data obtained are analysed using descriptive and inferential statistics. These studies tend to recruit clients at infertility clinics, and compare them either with the population norms provided for standardized tests, or with a fertile control group (Greil, 1997). Virtually all of the studies of psychological correlates of infertility have been carried out in the west.

Central to my review of this category of studies is Greil's (1997) widely quoted review of the psychological distress literature, although I have included more recent articles as well.

[11] This is likely to be the case in western countries as well, but more so in non-western developing countries, in which people are expected to fall pregnant sometimes within months after marriage.
[12] Qualitative, descriptive studies of psychological well-being in relation to infertility have been conducted as well. I do not discuss these in this section, because they are more similar to ethnographic studies (see section 2.3), as they connect experiences of infertility to the socio-cultural context (Greil, 1997).

2.2.1 Psychological correlates of infertility and its treatment

Until the 1980s, scholars were interested in psychological factors as causes, rather than consequences of infertility (van Balen, 2002; Greil, 1997). Unexplained infertility, that is when no biological cause of infertility can be established, was commonly attributed to psychogenic factors, such as unconscious ambivalence or resistance to becoming a mother (van Balen, 2002). Van Balen (2002) points out that nowadays, psychogenic explanations are more tentative, pertain mainly to stress, and are usually thought to perpetuate rather than cause infertility (Anderheim et al., 2005; Pook, Krauze & Rohrle, 2000; Lancastle & Boivin, 2005). However, more profound psychological attributions of infertility, to for instance unconscious psychodynamic factors (Haynes & Miller, 2002) or personality characteristics (Fasssino, Garzaro, Peris, Amianto, Piero & Daga, 2002) can still be found.

Since the late 1980s, studies tend to focus on the psychological *consequences* of infertility, and even more commonly, on the consequences of infertility *treatment*, like IVF procedures (van Balen, 2002). These studies compare clients of infertility clinics with 'healthy controls', using psychometric tests like the Hospital Anxiety and Depression Scale, which measures (trait and state) anxiety and depression (Lord & Robertson, 2005) or the General Health Questionnaire which measures somatic complaints, anxiety, social dysfunction and depression (van den Akker, 2005). Some studies use a psychometric assessment specific to infertility, like Fertility Problem Stress Inventory (Abbey et al., 1992). This inventory measures stress resulting from infertility in a personal domain (stress on mental and physical health), marital domain (strain produced by infertility on marital and sexual relationships) and social domains (effect of infertility on relationships with family and friends and workmates) (Abbey et al., 1991).

Most studies have indeed found an association between infertility (Aghanwa, Dare & Ogunniy, 1999; Souter, Hopton, Penney & Templeton, 2002; Dyer, Abrahams, Mokoena, Lombard & van der Spuy, 2005), or its treatment (Rajkhowa, 2006; Domar, 2004), and negative psychological consequences. However, there are also some studies which find no effect of infertility, or its treatment, on people's psychological well-being (Dhillon, Cumming & Cumming, 2000; Edelmann, Connolly & Barlett, 1994; van den Akker, 2005). In addition, when psychological

symptoms are observed, authors disagree about whether they fall within the clinically relevant range, that is whether scores regarding symptoms are not only higher than the average norm, but also elevated to the extent that they can be called pathological (Greil, 1997).

Studies have examined the effect of infertility or its treatment on marital satisfaction as well. Like other psychological correlates, marital satisfaction is normally measured with pre-existing scales, like for instance the 'ENRICH marital inventory' (Fowers & Olson, 1989). This inventory examines communication in the marriage, conflict resolution and sexual relationships, amongst other issues. Some of its subscales assess social relationships, outside the marriage, like feelings and concerns about relationships with relatives and friends.

Findings regarding the effect of infertility on marital relationships are mixed (Greil, 1997). For instance, Guttmann (2004) compares marital satisfaction of childless couples with the satisfaction of first time parents, and found that it was, on average, lower. On the other hand, Sysdjö, Ekholm, Wadsby, Kjellberg and Sydsjö (2005) found that infertile couples had stable relationships which they evaluated in a positive way, both before and after IVF treatment, and regardless of whether treatment had been successful. Greil (1991) found that relationships in couples facing fertility problems improved. Some authors argue that it is *differences* in men's and women's emotional and coping reactions to infertility, rather than infertility itself, that have a negative effect on the quality of and satisfaction with marital relationships (Merari, Chetrit, Modan, 2002; Pasch, Dunkel-Schetter, Christensen, 2002; Peterson, Newton & Rosen, 2003).

2.2.2 Psychological correlates and mediating factors: Gender, coping and illness cognitions.

Another theme in studies of psychological correlates of infertility is whether certain factors, such as gender, coping style and illness cognitions, mediate psychological consequences of infertility. Most studies which have looked at gender differences, claim that women react more adversely to infertility than men (Greil, 1997). However, some find no or few differences (Edelmann & Connolly, 2000; Berg, Wilson & Wingarter, 1991). Edelmann and Connolly's (2000) study is one of the few

which uses a longitudinal design to examined gender differences in psychological characteristics of infertility clients. They assessed infertility clients two or three times between the start and end of a treatment cycle. Although they found gender differences in psychological distress, these became smaller over time. In addition, Edelmann and Connolly (2000) point out that some of the gender differences which they found are to be expected as they are in accordance with default gender differences as recorded in normative scores of the psychometric tests they used. Therefore, they argue, as others have done (Berg et al., 1991), that several methodological flaws in infertility studies impair the validity of claims that psychological consequences of infertility are more severe for women. Examples of methodological problems are studies' cross-sectional rather than longitudinal design (Edelmann & Connolly, 2000), which renders making claims about the effect of infertility or its treatment difficult, and the failure of researchers to take into account that, in general, men tend to express psychological problems less intensively, and less frequently than women (Berg et al., 1991; Edelmann & Connolly, 2000).

Coping style is another mediating factor between infertility, its treatment, and psychological outcomes which has been examined, using standardized assessments like the COPE (Carver, Scheier, & Weintraub, 1989), or an infertility specific measurement like the Coping with Infertility Questionnaire (Benyamini et al., 2004). Infertility studies looking at coping largely conceptualise it as a cognitive process. Many studies drawn upon Lazarus and Folkman's (1984) model of coping with stress. This model proposes that coping is a response following *cognitive* appraisals of a threatening or taxing situation, in which the situation and possible reactions are assessed. Some studies of coping style and psychological consequences of infertility are informed by Leventhal's self-regulatory model of coping (Leventhal, Meyer & Nerenz, 1980; 1984). According to Leventhal et al. (1984), the first phase of coping is that, when faced with a health threat, people form various cognitions about features such as causes, controllability and severity. These cognitions subsequently inform people's response. Hence, also in this self-regulatory model, coping is seen as a cognitive process.

Lazarus and Folkman's (1984) model distinguishes between two kinds of coping: problem focused and emotion focused. Problem focused coping is

concerned with doing something about the stressor and solving the problem, emotion focused coping is aimed at reducing and managing the accompanying stress (Lazarus & Folkman, 1984). Others, like Carver, Scheier and Weintraub (1989) have subsequently refined these distinctions, and added new styles of coping, like denial, that is denying the reality of a stressor, mental disengagement, that is engaging in activities or thoughts to avoid thinking about the stressful situation, or positive re-appraisal of a stressor (Carver, Scheier & Weintraub, 1989). Some styles of coping are considered less functional than others, and therefore are seen as 'maladaptive' or 'dysfunctional', although it is acknowledged that this can differ per person and situation (Carver, Scheier & Weintraub, 1989).

Also regarding infertility, certain coping styles have been found to be associated with more negative psychological consequences (van den Akker, 2005; Benyamini, Gozlan & Kokia, 2004; Gannon, Butler, Glover & Abel, 2000; Hynes, Call, Terry & Gallois, 1992; Lord & Robertson, 2005; Schmidt, Holstein, Christensen & Boivin, 2005). For example, 'coping through avoidance' or 'seeking social support' has been found to be related to greater distress than 'problem focussed coping' and 'direct action' (Hynes, Callan, Terry & Gallois, 1992). Beyamini et al. (2004) found that 'inward-anger' strategies, such as denial, self-blame, self-neglect, social avoidance, were associated with reduced well-being and heightened levels of distress. On the other hand, 'self-nurturing' strategies such as self-care, keeping busy, investing in myself, were related to higher levels of well-being (*op cit.*).

Inspired by Leventhal's et al. (1984) idea that people form cognitions about features of the health threat such as causes, controllability and severity, which inform their coping response, some studies have examined people's illness cognitions regarding infertility, and their relationship with psychological outcomes. These studies commonly employ a standardized measurement to assess people's illness cognitions, like the Illness Perception Questionnaire (Weinman, Petrie, Moss-Morris & Horne, 1996), although qualitative assessments have also been used (Vieyra, Tennen, Affleck, Allen, McGann, 1990). Cognitions which have been found to be associated with greater distress are more severe perceived consequences (Beyamini et al., 2004; Stanton, Tennen, Affleck & Medola, 1991), less controllability

(Benyamini et al., 2004) and attributions of infertility (Lord & Robertson, 2005; Vieyra et al., 1990) and IVF failure (Litt, Tennen, Affleck, Klock, 1991) to factors related to oneself, like one's own actions. However, Abbey and Halman (1995) found that self-attributions were *un*related to life quality, whereas attributions of infertility to physicians were negatively related to measurements of quality of life. Litt et al. (1991) found that women's attribution of infertility to one's own actions rather than to others was negatively associated with distress felt after IVF failure. They suggest that 'some women may need to have a sense that the world is not uncontrollable' (Litt et al., 1991: 183). In addition, Vieyra et al. (1990) note that findings regarding attributions and distress have to be interpreted with caution. They found that for all attributions which they measured, including behavioural self-blame, but also chance and biomedical factors, stronger endorsement of an attribution was associated with greater distress. They point out that the direction of the association is unknown and suggest that greater distress may stimulate people to search for causes of their infertility.

As certain coping styles and cognitions are more associated with negative outcomes, a common suggestion is that some people's problems can be alleviated by cognitive therapy, which can help them change their 'unhelpful' cognitions and coping styles and decrease their negative psychological effects (van den Akker, 2005; Benyamini et al., 2004; Lord & Robertson, 2005).

2.2.3 Health seeking behaviour

Psychological correlates have been studied as well in relation to people's health seeking behaviour for infertility, in terms of, for instance, decision-making and motivations. Van Balen, Verdurmen and Ketting (1997) conducted a survey about the different kinds of actions, which couples can engage in to solve a fertility problem (i.e. medical help, adoption, and foster care), and the motivations associated with these different options. Desire to have a child was the motive most frequently mentioned, for all options, and altruistic motives were mentioned most frequently by those considering adoption and foster-care. In another survey study, van Balen and Verdurmen (1999) found that uneasiness and anxiety about medical settings was associated with rejection of medical treatment and choosing alternative options like

adoption. In a survey, Greil and McQuillan (2004) investigated health seeking behaviour of American 'subfecund' women. They found factors like (lower) locus of control, intent to become pregnant and self-identification as having a fertility problem to be related to the seeking of medical help, as well as (higher) income and (higher) education level. Rhajkowa, McConnell and Thomas (2006) found in their survey study that stress was one of the main reasons for couples to stop IVF treatment, and Domar (2004) reaches a similar conclusion on the basis of a literature review. According to Peddie, van Teijlingen and Bhattacharya (2005) unrealistic expectations about treatment are related to people's decision to stop treatment.

2.2.4 Conclusion

Studies of psychological correlates of infertility show that overall, infertility and its treatment has an impact on people's, and especially women's, psychological well-being. However, there is some ambiguity regarding the extent to which well-being is affected, as well as regarding the effect of infertility on marital satisfaction. Psychological consequences have been found to be mediated by various factors like gender, coping style and cognitions, although these results are equivocal. Several psychological factors (e.g. motivations, locus of control) and demographic factors (e.g. income and education), have been found to correlate with, and thus to some extent predict, people's health seeking behaviour. Discontinuation of IVF treatment appears associated with the stress which it causes.

Greil (1997, p.1700) describes the psychological distress literature as disappointing: the outcomes are often ambiguous, and many seem unsurprising. This goes for example for the finding that anxiety about medical settings results in not using medical treatment (van Balen & Verdurmen, 1999), or that 'inward-anger' coping strategies are related to lower well-being and more distress. Greil (1997) suggests that the disappointing results of quantitative psychological studies of infertility are due to several methodological and conceptual shortcomings. First, studies use a selective sample of participants. They tend to focus on those seeking treatment, in particular in the form of assisted reproductive technologies, like IVF (Greil, 1997). Therefore, people who do not seek treatment are excluded, and as

these are more often people who belong to ethnic minorities or lower socio-economic classes, these groups are under-represented as well (*op cit.*).

In addition, there is an over-reliance on women (Greil, 1997). Although there are various studies in which both men and women participated, these tend to focus specifically on gender differences, thus necessitating involvement of both sexes. Authors usually do not explain why they include only women. When they do, a common argument is that women carry the main burden of infertility (Benyamini, Gozlan & Kokia, 2004; Dyer et al., 2005; Van den Akker, 2005). However, this claim does not seem to warrant the exclusion of men, as it requires a comparison between men and women. In addition, if infertility is more problematic for women, this does not mean that it is *not* distressing for men.

A second, more fundamental conceptual shortcoming of these studies of psychological correlates, identified by Greil (1997), is that they do not acknowledge the relevance of the socio-cultural context and transform 'what should be understood as a characteristic of a social situation' into a trait of individuals (Greil, 1997: 1693). The individualistic approach of psychological studies is demonstrated by their focus on internal states, like anxiety and depression, and their attention to social relationships in terms of individuals' cognitions or feelings about them, as demonstrated by the concept 'marital satisfaction'. In addition, coping and decision-making are conceptualised as internal processes, based on people's cognitions. An implication of this individualistic cognitive approach is that alleviation of the burden of infertility is sought in cognitive therapy for people with a fertility problem, in which they can learn to change their perceptions and cognitions. Thus, socio-cultural aspects also tend to be ignored as potential starting points for alleviating consequences of infertility. The conceptualisation of the hardship of infertility as dependent on people's maladaptive cognitive responses seems unfortunate, as it can lead to victim blaming (cf. van Balen, 2002).

The studies by Aghanwa, Dare and Ogunniyi (1999) and Dyer et al. (2005) are exceptions in that they acknowledge the need to tackle socio-cultural practices and meanings, in addition to providing counselling for people with a fertility problem. Interestingly, these studies are the only two studies in non-western developing countries which I have found of psychological correlates of infertility.

However, the almost exclusive focus on western, developed countries is not acknowledged; studies suggest that the phenomena they examine, and their findings, are of universal relevance and applicability. This can be inferred for example from titles like 'choices and motivations of infertile couples' (van Balen, Verdurmen, Ketting, 1997) or 'differences between husbands' and wives' approaches to infertility' (Pasch et al., 2002). This is then, another illustration of the neglect of the socio-cultural nature of infertility. As Greil (1997: 1693) explains, 'if one does not conceptualise infertility as social constructed, one might not stop to think that different groups might construct it differently'.

Greil's (1997) review is published in the high impact journal of *Social Science and Medicine*, and widely cited: 77 citations are reported in the database of Web of Knowledge as of October 2006. However, whilst authors refer to Greil's (*op cit.*) overview of findings regarding psychological distress, the methodological and conceptual criticism, which he put forward in the same article, is virtually ignored. One possible explanation for the lack of methodological and conceptual reflexivity in studies of psychological correlates can be found in van Balen's (2002) work. He argues that much of the psychological research agenda is dictated by the medical profession, which has a vested interested in having a large clientele, and thus in understanding the effect of psychological factors on patients' satisfaction, on (dis)continuation of treatment and on success rates of assisted reproductive technologies. The medical research agenda of infertility studies could explain the over-representation of clients of infertility clinics; the larger interest in psychological consequences of treatment procedures than of infertility itself (van Balen, 2002); and more in general, the individualistic approach of many infertility studies, which, as Greil (1997) points out, fits in with a medical model of illness. One could even argue that the conceptualisation of infertility distress as the outcome of individualistic, potentially pathological traits, to be remedied by counselling and psychotherapy, is in the interest of the medical profession.

Thus, after nine years and 77 citations, there is still a strong need to take into account Greil's (1997) recommendation to re-direct attention to social actors with a fertility problem rather than infertile patients, to infertility as a social state rather than medical condition, and to social conditions which shape the experience of infertility

(cf. Dyer et al., 2005). As I will show in the next section, ethnographic infertility studies, pay much more attention to the social context of infertility.

2.3 Ethnographic studies: Experiences and perceptions of infertility

Since the second half of the 1990s, scholars' interest in infertility in the developing world has increased (van Balen & Inhorn, 2002). In particular, there is a growing number of studies which describe local experiences and perceptions of infertility, its causes, solutions and consequences. Studies have examined infertility in various non-western developing countries. However, no study has yet examined local views of infertility in Malawi. Four main themes which are examined in these studies of local experiences and perceptions are perceived causes of infertility**,** health seeking behaviour**,** solutions offered, and psychological and social consequences of infertility. A fifth, less central theme in these studies is how individuals manage the stigma of infertility and their infertile and gender identities.

These studies use predominantly qualitative methodologies, and tend to collect several types of data. Particularly common is the combination of semi-structured interviews and observations. They relate their findings to the socio-cultural context. Considering these features, these studies can be said to be of an ethnographic nature. The form of data analysis used is usually left implicit, but often seems to be a form of thematic analysis, in which relevant themes are deduced from the content of people's statements[13].

The field of descriptive studies of experiences and perceptions of infertility in developing countries is relatively young and very much in development. Although this makes it difficult to identify seminal papers, it is clear that Inhorn's (1994) work on infertility in Egypt is of major influence. Her book 'Quest for conception: Gender, Infertility and Egyptian Medical Traditions' (Inhorn, 1994) was the first detailed account of the experiences of infertile women in a non- western country.

[13] See for further methodological details table 4 in the appendix

2.3.1 Causes from indigenous perspectives

Many studies of infertility in developing countries discuss local or indigenous 'knowledge', 'perceptions' or 'beliefs' regarding causes, terms which tend to be used interchangeably. Indigenous perceptions are often compared and juxtaposed with biomedical knowledge regarding causes, as described in epidemiological studies. Sometimes, local and biomedical ideas are found to overlap. For example, studies have found that people consider abortion and sperm abnormalities (Gerrits et al., 1999), blocked tubes (Dyer et al., 2004) and STDs (Dyer et al., 2004; Gerrits et al., 1999, Mariano, 2004) to be causes of infertility. More attention is paid, however, to differences in biomedical and indigenous perspectives. Thus, various 'indigenous' beliefs regarding causes have been reported, including the use of indigenous and biomedical contraceptives, that is condoms, the pill, IUDs and injectables (Agadjanian, 2001, Gerrits et al., 1999, Upton, 2001). Gerrits (1997) reports that in Mozambique, incompatibility of blood of a particular man and woman is thought to be a cause of infertility.

Some causes have been categorised as 'personalistic explanations' (Foster & Anderson, 1978), according to which a health problem is caused by people or supernatural beings and forces, like spirits or witches. Personalistic explanations of infertility in the developing world pertain especially to ancestral spirits (Gerrits et al., 1997; Sundby et al., 1998; Sundby, 1997, Mariano, 2004) and witches (Dyer et al., 2004; Feldman-Savelsberg, 1994; Gerrits et al., 1997; Sundby 1997). Spirits are usually seen as able to cause infertility when disturbed due to problematic social relationships (Neff, 1994) or bad behaviour (Mariano, 2004). Witches' help is thought to be evoked by jealous people, especially co-wives, mothers in law and neighbours (Dyer et al, 2004; Feldman-Savelsberg, 1994; Sundby 1997). In addition, the idea that infertility is due to God's will has been reported (Sundby, 1997; Gerrits *et al.*, 1999), at times seen as a punishment for sins people committed (Meera Guntupalli & Chenchelgudem, 2004, Neff, 1997).

Another personalistic explanation found is that infertility is attributed to people's transgression of certain behavioural norms. Examples of such transgressions are women's neglect of ancestors, disrespectful treatment of parents and husbands, (Feldman-Savelsberg, 1994), eating certain foods, like pumpkins or gourds (Upton,

2001), widows not observing a period of sexual abstinence (Upton, 2001). Sundby (1997, p. 6) remarks that in many West-African countries infertility is regularly related to 'misuse of the body', which includes promiscuity or other undesirable sexual behaviour and abortion. Note that thus, especially *women's* violations are reported; men's violations of taboos as cause of infertility are referred to much more rarely. Upton (2001) however, mentions that in Botswana, fertility problems can be attributed to transgressions of sexual norms by men. For instance, sleeping with another woman when one's wife is pregnant is seen as a risk factor for miscarriages.

Some authors point out that people may consider various causes relevant for their fertility problem, and may believe in both biomedical and indigenous causes (Inhorn, 1994; Sundby, 1997). In addition, Inhorn (1994) points out that ideas about causes are likely to vary over time, and that there is not necessarily a cultural consensus about causes.

Although a wide range of indigenous causes is reported, authors also note the limited knowledge of people regarding causes of infertility (Meera Guntupalli & Chechelgudem, 2004; Sundby, 1997). This judgement is based on the observation that people's knowledge is not in agreement with biomedical knowledge, or that respondents themselves say that they do not know the causes of infertility, in general, or regarding their own condition (Dyer et al., 2004; Papreen et al., 2000).

Several authors note that infertility is often considered a problem residing in the woman. This is often seen as support for the argument that women are seen as to blame for infertility, something which virtually all authors note (e.g. Gerrits et al., 1994; Riessman, 2000; Inhorn, 1994, 2004). For instance, Riessman (2000) reports that Jindal and Gupta (1989) found 'considerable self-blame' in women visiting a fertility clinic in India, as a common statement by the women was 'there is something wrong with me'. Inhorn (2004, p.245) explains how indigenous ideas about procreation in Egypt imply that it is always the woman who is seen as the infertile partner, and talks about this in the context of 'procreative blame'. It should be noted however that the two issues, of ideas about which partner is seen as infertile and who is seen as to blame, do not map onto each other in a straightforward way. For example, Meera Guntupalli and Chechelgudem (2004, p. 253) state 'even though women were blamed for infertility, women knew that men could be responsible for

the problem (…)'. Likewise, Sundby (1997, p. 31) mentions that 'most women know that infertility can be a man's fault but say that the women are often blamed'. Thus, drawing conclusions about who is blamed for infertility based on statements about who is considered to have the problem, and vice versa, seems problematic.

2.3.2 Health seeking behaviour

A second theme commonly addressed in ethnographic studies of infertility in the developing world, concerns people's health seeking behaviour.

Like epidemiological and demographic studies, ethnographic studies report that the use of biomedical services for infertility is common. Sundby et al. (1998) for instance, found that 16% of the gynaecology cases in a hospital in the Gambia were infertility clients, and higher rates, of up to 33% have been reported in Zimbabwe, South Africa and Nigeria (Rowes, 2000). Okonofua (1996) even argues that in Nigeria, infertility is the main reason for gynaecological consultations.

It appears that usually women consult western health practitioners, on their own or accompanied by relatives. This even if they know their husbands may be the cause of the infertility problem (Gerrits et al., 1999, Inhorn, 2003; Sundby, Mboge & Sonko, 1998; Sundby, 1997). Sundby (1997) found in her study in the Gambia that doctors may contribute to this gender pattern as they hardly ever requested to see the male spouses.

As reported in epidemiological and demographic studies, some ethnographic studies report that people wait relatively long before seeking help in western health centres. Sundby et al. (1998) found a seemingly long period of between 2 and 3 years, between onset of the infertility problem and consulting a doctor. Gerrits (1997) reports a large variety in the time during which women had had an infertility problem before they sought help: 6 months to 10 years. In addition, some studies (Gerrits, 1997; Sundby et al., 1998) report that many people with a fertility problem, between 40 and 60 percent, did *not* seek help from biomedical health services.

People appear to use indigenous health care more often than biomedical care (Gerrits, 1997; Sundby, 2002). As was found in epidemiological studies, people consult healers frequently: Gerrits (1997) reports that some Mozambiquan women paid up to 30 visits to an indigenous healer. Several authors note that people consult

indigenous healers *before* attending western health services for an infertility problem (Gerrits, 1997, Sundby, 1997; Sundby et al., 1998). According to Sundby (1997, p. 36), biomedical health care often comes 'as the last resort after indigenous care has failed.' This could explain the relatively long time that people sometimes wait before they consult biomedical practitioners. However, Inhorn (1994) notes that in Egypt, people with a fertility problem also often consult indigenous healers after having been to biomedical practitioners. 'Doctor shopping' appears to be common, in that people often consult large numbers of physicians, and both indigenous and biomedical practitioners (Inhorn, 1994; Sundby, 1997, Unisa, 1999).

Ethnographic studies also describe solutions sought outside indigenous or biomedical health care. Several authors mention how especially men frequently engage in extramarital relationships in an attempt to produce offspring with another partner (Gerrits, 1997; Mariano, 2004; Meera Guntupalli & Chechelgudem, 2004; van Balen & Bos, 2004). This practice is coined by van Balen and Bos (2004, p. 246) as 'the poor man's Artificial Insemination by Donor'. Fostering other people's children, either orphans or children of relatives, is considered a solution by some couples in sub-Saharan Africa (Gerrits, 1997; Sundby, 1997). Furthermore, sometimes special rituals are performed to solve fertility problems (Sundby *et al*, 1998; Neff, 1997). Sundby et al. (1998) describe the existence of a special 'fertility group' in the Gambia, in which rituals are performed which are aimed at child survival and advice is given regarding infertility treatment.

A few authors note that some people do not seek help, in general (Unisa, 1999) or from western health care specifically (Sundby et al., 1998), and list reasons which people give for their inactivity. Reasons mentioned are costs involved (Sundby et al., 1998; Unisa, 1999, p. 895), lack of information (Unisa, 1999), or 'not knowing where to seek help' (Sundby et al., 1998, p. 985). For the women in Unisa's (1999, p.56) study of infertility in India, one major reason for not seeking treatment was that 'it was not necessary'. Sundby et al. (1998, p. 985) report that in the Gambia, 'some related it to the husband's unwillingness to seek help'.

Overall, it appears that in developing countries, people with a fertility problem seek solutions relentlessly, whether from biomedical or indigenous sources (Berer, 1999; Inhorn, 1994; Sundby, 2002; van Balen & Gerrits, 2001). In so doing,

they make large financial (Inhorn, 1994; 2003; Unisa, 1999), and sometimes even physical (Inhorn, 1994; 2003; van Balen & Gerrits, 2001) sacrifices (see section 2.3.3).

2.3.3 (Medical) Solutions offered

A few ethnographic studies describe the biomedical and, to a lesser extent, indigenous treatment offered to infertility patients. Inhorn's (1994) study provides an exceptionally detailed description of biomedical and indigenous methods of treatment. Especially in sub-Saharan Africa, means to diagnose infertility are limited (Gerrits et al., 1999; Sundby et al., 1998). Sundby et al. (1998) list the diagnostic means available in the Gambia: STD tests, sperm count, and hystero-salpingograms, a technique whereby dye is injected in the fallopian tubes to render blockages visible. However, these diagnostic tests are only carried out in Gambia's main referral hospital or in a few private clinics. In addition, Sundby et al (1998) found that many patients in hospitals and clinics were seen only once. This suggests that many clients did not get their test results, and that they were thus of little use.

The treatment available for infertility is often limited as well. For instance, surgery to open blocked fallopian tubes, one of the most common causes of infertility, is a rare procedure in sub Saharan African countries (Sundby *et al.* ,1998). Even rarer is in vitro fertilisation (IVF), which would be another possibility to achieve pregnancy when tubes are blocked (cf. Vekemans, 1994). STDs are amongst the main causes of infertility in sub-Saharan Africa, but treatment for them is not always available. Gerrits (1997) for instance found that in the district capital Montepuez in Mozambique antibiotics were often not available. Nor was the contraceptive pill, which is sometimes used in order to treat irregular menstrual cycles. When no medicines are available, women are referred to a hospital in a bigger town, 200 km away, but Gerrits (1997) notes that women often do not go.

In addition to problems with availability of diagnostic procedures and treatment, problems with the quality of infertility care have been observed (Sundby, 2002). Sundby (2002) mentions that in the Gambia and Zimbabwe, clinics are overburdened and lack skilled workers. Both Inhorn (1998) and Sundby (2002) found that physicians in respectively Egypt, and the Gambia and Zimbabwe,

regularly carry out medical interventions which are ineffective and potentially harmful. Examples are electrocauterization of the cervix, in which tissue of the cervix is destroyed, which can lead to permanent damage of the cervix (Inhorn, 1994; Inhorn & Buss, 1994), and dilatation and curettage (D& C). This is a procedure in which tissue from the uterus is removed, and which can lead to infections if not carried out in sufficiently hygienic circumstances (Inhorn, 1994; Sundby, 2002). Inhorn (1994) notes that in Egypt, biomedical practitioners at times prescribe treatment without having derived a diagnosis, or do not discuss their diagnosis with their patients. She also argues that practitioners' base their diagnoses often on contingent factors, such as which factors are seen as easiest to diagnose or as most common. Furthermore, Sundby (2002) found that in the rural areas of the Gambia, few nurses have a special interest in infertility, and that expatriate doctors did not see infertility as a priority for which they should offer specialized treatment. At the same time, Sundby (2002, p. 252) notes that consultations for infertility can be difficult and require special skills and patience as infertility clients often do not directly reveal their problem to medical personnel, and instead provide vague reasons like 'pain in the body' or 'something wrong in the pelvis'. This may decrease practitioners' motivation to help these clients even further. It thus seems likely that also attitudes and motivation of practitioners working in developing countries contribute to the limited quality of care for infertile clients.

There is little information available about care provided by indigenous healers in sub Saharan Africa, although Gerrits (1997) reports several indigenous treatments, offered to infertile women in Mozambique: herbal teas, balms, baths and exorcism rituals in case of spirit possession. In addition, both Gerrits (1997) and Sundby (1997) mention how, in respectively Mozambique and the Gambia, indigenous healers provide medicine in the form of texts of the Koran, enclosed in amulets or washed in water which should be drunk.

2.3.4 Consequences of infertility

Ethnographic studies describe infertility as a serious health problem with many negative consequences (Dyer et al., 2002; Gerrits et al., 1999, Inhorn, 2003; Sundby, 1997, Upton, 2000). The highly problematic nature of infertility is usually attributed

to the social importance of childbearing and strong social norms to reproduce (Dyer et al., 2002, Inhorn 1994, 2003; McDonald Evens, 2004; Riessmann, 2002, 2005). Women especially are said to suffer and to bear the brunt of infertility problems (Dyer et al., 2002; Dyer et al., 2004; Inhorn, 1994; Inhorn & van Balen, 2000). This claim appears to be based mainly on the idea that women are usually blamed for infertility (Inhorn, 1994, 2003, Gerrits et al. 1997; Papreen, Sharma, Sabin, Begum, Ahsan, Baqui, 2000). In addition, some authors note that having children is essential for especially women's adult and gender identity (Riessman, 2002; Harrison & Montgomery, 2001; Walraven et al., 2001).

Similar to studies of psychological correlates of infertility, ethnographic studies report that infertility leads to psychological distress. They do so on the basis of observations such as infertile respondents crying during interviews (Dyer et al., 2002), stating that they feel sad (Gerrits, 1997; Sundby, 1997) and reporting that they are worried, for instance about family continuation, support in old age, and about who would mourn them when they die and take care of their funeral (Gerrits, 1997). It appears that infertility can at times lead to extreme psychological distress: Dyer et al. (2002) mention that some respondents reported suicidal thoughts. Papreen et al. (2000), report as well that several community members said that infertility can push a woman to commit suicide, although none of the infertile respondents themselves mentioned this.

In addition to psychological consequences, many social consequences of infertility have been noted, at a community, family and conjugal level (Gerrits et al., 1998). Studies report that in communities, people with a fertility problem are stigmatised (Dyer et al., 2002; Gerrits, 1997; Inhorn, 2004; Mariano, 2004; Neff, 1994; Riesman, 2002, 2000; Sundby, 1997), and socially excluded from various activities like deliveries (Gerrits, 1997), (birth and burial) rituals (Gerrits, 1997), or weddings (Neff, 1994). People with a fertility problem are reported to be verbally abused by community members (Dyer et al, 2002; Papreen, 2000; Riesman, 2002; Upton**,** 2001). For instance, infertile women are bothered by gossip (Sundby, 1997), and ridiculed (Riesman, 2002). Upton (2001) mentions how infertile women in Botswana are often compared to barren animals.

Infertility appears to be a problem at the level of family relationships, in that infertile women feel pressurised to get pregnant, and are blamed for failing to bear children by their family (Gerrits, 1997) and especially family-in-law (Dyer et al., 2002; Pashigian, 2002). Several authors mention that infertile women are taunted by their family and family-in-law. Papreen et al. (2000, p. 38) describe how an infertile woman was told by her mother-in-law 'it is better to see the face of a dog than to see your face this early in the morning'. A respondent in the study by Dyer et al. (2002, p. 1665) was accused of causing their own infertility by her mother, who told her: 'Where's all the children? Every time you are pregnant you drink them away... (you) flushed them down the toilet. '

An issue which may underlie problematic behaviour towards infertile relatives is that a couple's infertility can be problematic for the whole family and kinship group (Gerrits, 1997; Neff, 1994; Onah, 1992). Onah (1992) mentions that in Nigeria, unmarried relatives of an infertile couple are not considered eligible for marriage. Neff (1994) explains that among the matrilineal Nayar in south India, the whole kinship group is held responsible for a woman's infertility as they are expected to protect a woman from harmful forces like Gods or demons, which can affect fertility, and from disharmony in the matrilineal kin group, which might disturb the family fertility spirit. Therefore, a couple's infertility can problematize relationships of a kinship group with others in the community.

Considering the impact which infertility can have on families, it seems not surprising that family members are often involved in seeking solutions. Gerrits (2002) mentions that during hospital consultations, women are more often accompanied by relatives than by their husbands. In addition, family members have been found to pressurize male relatives to divorce their wives if they are thought to be infertile (Gerrits *et al.*, 1999; Papreen et al., 2000; Pashigian, 2000).

This suggests that infertility is a potential source of trouble for spousal relationships. Indeed, several studies found that when a marriage remains childless, men at times abuse their wives, verbally and even physically (Dyer et al., 2002; Papreen, 2000; Riessman, 2005; Unisa, 1999). In addition, it appears common that men divorce their wives, take another wife, or engage in extramarital affairs (Gerrits et al., 1998; Inhorn, 2003; Sundby, 1997). Gerrits (1997) reports that among the

Macua in Mozambique, women themselves also engage in extramarital relationships. However, this is seen as an exception due to the matriarchal organisation of this ethnic group.

It should be mentioned though, that the extent to which infertility leads to actual marriage breakdown, remains unclear. This is so, first because most authors report women's *worries* about abandonment by their husbands (Gerrits, 1997; Papreen et al, 2000; Sundby, Mboge & Sonko, 1998; Sundby, 1997; Dyer et al., 2002). Reports of actual divorce and abandonment are more rare, and seem usually based on reports by community members (Papreen et al., 2000). Second, several authors note that spousal relationships do not always become problematic, and may even become better (Dyer et al., 2002; Gerrits et al., 1999; Inhorn, 2003; Pashigian, 2000; Riessman, 2005). Third, many of the infertile research participants in epidemiological and ethnographic studies are married, although some have had previous marriages, which may have broken down due to their fertility problems.

Nevertheless, overall, it can be concluded that infertility is found to be serious problem in developing countries, including sub Saharan Africa. This is so especially in terms of its social consequences, as reflected in authors' classifications of infertility as a 'disease of social relations' (Neff, 1994, p.477), 'a central existential intrapersonal and relational conflict' (Sundby, 1997, p. 30) and 'a question of social balance' (Mariano, 2004, p. 268).

2.3.5 Management of stigma and identity

A final theme in some ethnographic infertility studies, is how individuals manage the stigma of infertility, and its effect on their (gender) identities. Several authors hint at the relevance of causal attributions in the management of the stigma of infertility. Upton (2001) for instance, points out that if people attribute a woman's infertility to a violation of social norms, this makes her liable for her own (health) problem. On the other hand, by attributing infertility to external factors like witchcraft or God's will, people can place the blame for infertility outside themselves (*op cit.*). Moreover, Upton (2001) argues that causal attribution can be used in the negotiation of one's fertility status and identity. Attributing infertility to witchcraft, for example, is a way to be considered as in principle fertile, but bewitched and therefore not

producing children (anymore). Feldman-Savelsberg (1999, p.467-468) describes the case of a queen of a kingdom in Cameroon, who had several imaginary pregnancies. When one of her co-wives made sarcastic remarks about her motherhood, the queen accused her of stealing her child. This suggests as well that witchcraft accounts can have a function in the negotiation of one's (in)fertile status, or one's responsibility for it. In addition, the case of the queen which Feldman-Savelsberg (1999, p.467-468) describes suggests that imaginary pregnancies can have a function in the negotiation of one's (in)fertile status. Papreen et al. (2000) note as well the occurrence of imaginary pregnancies; women claim to have been pregnant but to have lost the pregnancy. The authors argue that this ameliorates their childless status.

Whereas some studies discuss people's management of stigma and identity in passing, this theme is central in Riessman 's (2002, 2005) work on infertility in India. Riessman (2002) discusses how women can manage their infertility in relation to their (gender) identity by means of causal attribution. The extract below is part of an extract which Riessman (2002, p.154) discusses:

L: What do you think is the reason why you do not have children?
A: I think that it must be because I am so old.
That is my opinion.
Other than that, no other problem
There is this [name] hospital in Alleppey
There- I had gone there for treatment
Then the doctor said that- after doing a scan
The way through which the sperm goes
There is some block

In her analysis of this narrative, Riessman (2002) explains how the woman positions herself as a 'the knowing subject', who knows that she is infertile due to her age, rather than an internal flaw, or 'some block'. Riessman (2002) refers to another respondent who mentions that the doctor told her 'you are perfectly- no defect at all'. Both women, according to Riessman (2002, p. 166), reject blame and responsibility for their infertility and 'perform positive identities (…) which transcended stigma and victimization'.

In another paper, Riessman (2000a), inspired by Goffman (1963), discusses in detail strategies to manage the stigma of infertility. Examples of strategies which she inferred from in-depth interviews with childless Indian women are ‘resistant thinking’ (not taking insulting remarks seriously), ‘strategic avoidance’ (avoiding neighbours and, thereby, potentially hurtful remarks), and ‘speaking out and acting up’ (rejecting blame for infertility and telling the husband that he is or might be to blame for the infertility).

2.3.6 Conclusion

Ethnographic studies of infertility in developing countries provide insight into the wide range of local perceptions of causes of infertility, and how these can be both similar and different to a biomedical perspective on causes. In addition, the studies show that people commonly seek help for fertility problems, especially from indigenous healers. They demonstrate as well that the quality and range of biomedical solutions offered is limited, due to a lack of resources, and possibly also due to a lack of interest on behalf of medical staff. Furthermore, ethnographic studies have shown overwhelmingly that infertility is a serious problem, especially in terms of its social consequences. These problems are seen as related to socio-cultural norms, which mandate parenthood. Infertility is seen as a serious problem, especially for women. At the same time, some studies draw attention to how people can actively manage the stigma of infertility and its effect on (gender) identities. Riessman for instance (2000a, b) states explicitly that (Indian) infertile women should not be seen as passive victims of their culture.

Unlike psychological studies, ethnographic studies connect infertility and the issues involved to local socio-cultural contexts. This is reflected in (sub) titles such as 'The exceptional case of the Macua in Mozambique.' (Gerrits, 2002) or ‘Perceptions, causes and consequences of infertility among the Chenchu tribe of India’ (Meera Guntupalli & Chechelgudem, 2004). In addition, ethnographic studies pay attention to social, normative and moral issues involved in infertility. They have identified how, from local perspectives, infertility can be attributed to various social factors, like problematic relationships or violation of behavioural norms. The problematic nature of infertility is seen to arise from strong pronatalist norms, which

mandate parenthood and make infertility into a morally problematic, deviant state. Moreover, causes are linked to moral issues in discussions about who is considered to be 'at fault', and thus blamed for infertility problems.

Considering the attention given to the social nature of the problem of infertility, it is remarkable that several social actors tend to be excluded in infertility studies in the developing world. Usually, research participants are community members, or infertile women. Men are noticeably absent in infertility studies. Exceptions are the studies of Agadjanian (2001), Dyer *et al.* (2004), and Inhorn (2003). Inhorn (2003) however discusses male infertility in terms of its influences on *women's* experiences of infertility. Others have noted this omission in the literature regarding men's views as well (Gerrits et al., 1999; Mbizvo & Basett, 1994), but the issue has seldomly been addressed. As in psychological studies, arguments for the focus on women are missing or pertain to the idea that women bear the brunt of infertility problems. As mentioned, this conclusion is problematic, as it requires a comparison of women's and men's experiences. In addition, the few studies in which men did take part, report serious negative consequences for men as well (Dyer et al., 2004; Inhorn, 2003). For instance, Mbzivo and Basett (1996) and Upton (2001) state that men's fertility is more or less taken for granted, and therefore being infertile leads to more psychological problems for them.

Besides men, significant others of people with a fertility problem, such as relatives and friends, are seldom part of studies of infertility in the developing world. When studies include biomedical and indigenous practitioners, their views are usually not discussed in detail. Data obtained from these participants tends to serve as factual information about what medical care is offered. There are however medical sociological studies, which have analysed in detail biomedical practices regarding infertility, and have revealed their social, normative and moral bases and consequences. I will discuss some of these in the next section.

2.4 Social aspects of biomedical practice in relation to infertility

Some studies of infertility, usually carried out by medical sociologists, have examined the social, normative and moral nature of biomedical practices in relation

to infertility, as medical sociologists have done regarding biomedicine in general (Brandt & Rozin, 1997; Lupton, 1994). These studies normally use qualitative methodologies, relying on interview data, documents, or to a lesser extent, surveys (see table 5 in the appendix). Several of these studies are of a historical nature. For instance, both Pfeffer (1993) and Sandelowksi (1999) have carried out a historical analysis of mainly medical papers and case studies published on infertility in the 19th and 20th century. Most studies of the social, normative and moral nature of biomedical practice in relation to infertility focus on the west[14]. An exception is Inhorn's [15](1994) study. In her discussion of infertility in Egypt, she pays considerable attention to indigenous and biomedical medical practices, including their social bases.

Three themes can be discerned in these studies: the social, interested nature of medical practice; the normative and moral bases of diagnoses; and how moral categorisations affect patients' access to care.

2.4.1 The interested, normative and moral nature of medical practice

Inhorn (1994) draws attention to the social nature of biomedical practice in Egypt, in that she points out how it is informed by practitioners' interests. To begin with, she notes how practitioners' lack of communication about their diagnoses to their patients is in their interest, in that it is a way to maintain power differences and professional boundaries.

In addition, Inhorn (1994) notes that in Egypt, invasive medical procedures are common, such as tubal insufflation (involving passing dye through the cervix, uterus and fallopian tubes) and dilatation and curettage of the uterus. She argues that although the benefits of these procedures are doubtful, they are performed in part because practitioners have an economic interest in doing so. They are an important source of income for practitioners, certainly for those working in the private sector, and these procedures are popular with people in search for a cure for their fertility problem, making them a way to attract clients (Inhorn, 1994).

[14] As said (footnote 7) there is a growing body of literature on assisted reproductive technologies (ART) in developing countries. These examine as well the political and thus social nature of these technologies. However, as ART is rare in sub Saharan Africa and absent in Malawi, I do not include these studies in this literature review.

[15] I have discussed Inhorn's (1994) work as well in the previous section on ethnographic studies. Inhorn's work is atypical and cuts across categories.

Some authors have paid attention to the normative bases and moral consequences of diagnoses. Pfeffer (1993) explains how, in the 19th and 20th centuries, diagnoses of infertility were based on normative expectations and on a notion of infertility as deviation from the norm. For instance, doctors relied on norms regarding women's physical appearance in their diagnoses, in that masculine bodily features in women were seen as an outward sign of reproductive health problems. Behavioural norms were regarded as relevant, in that leading idle lives or being particularly sexually active were seen as signs of decreased fertility.

Both Pfeffer (1993) and Sandelowski (1990) point out how such attributions of infertility to behaviour make people, in particular women, to blame for their infertility. This goes as well for attributions of infertility to women's volition (Sandelowski, 1990), such as psychoanalytic explanations which attribute infertility to an ambivalence towards maternity, and absence of a true desire for children (Sandelowski, 1990; van Balen, 2002). Attributions of infertility to decisions to delay childbearing, which emerged towards the end of the 19th century, make women responsible for their own infertility as well. In addition, it makes women morally suspect by portraying them as egocentric because they forego 'duties', such as being a mother, housewife and contributing to the continued existence of society, for selfish reasons like wanting to pursue careers (Sandelowksi, 1990).

Medical sociologists have also drawn attention to how practitioners' creation of moral categories of patients, for instance based on diagnoses, can affect access to infertility services. Pfeffer (1993) notes that in the 19th century, some hospitals would not treat men or women who were seen as infertile due to self-inflicted STDs. Malin (2003) shows how also nowadays, physicians do moral categorisation work. She found in her interview study of Finnish physicians who provide assisted reproductive technology (ART), that they defined categories of infertility patients as (more and less) 'troublesome', 'good' and 'bad'[16]. For instance, career oriented women and women with psychosocial and health problems were constructed as troublesome patients, less good 'mothers to be' and inappropriate candidates for ART. Access to

[16] Health practitioners' moral categorisations of 'good' and 'bad' patients has been described in studies of practitioners in other biomedical fields as well, like practitioners working in paediatrics (White, 2002) and casualty departments (Jeffery, 1979).

ART for these women could be delayed or denied. Steinberg (1997) examined criteria for patient screening in British IVF clinics. She found that some selection criteria were based on sexuality and lifestyle: many physicians argued that couples who were not heterosexual, and not married or in marriage-like relationships, should not be assisted to reproduce. Thus, as others have done (Davis, 1990; Fried, 1990; Malin, 2003; Mort, 1987), Steinberg (1997), argues that the practitioners restrict the reproductive choice of women, and that biomedicine is an institution of social control, immersed with ideas about who can legitimately reproduce.

2.4.2 Conclusion

Some studies have drawn attention to the social, normative and moral nature of biomedical practice in relation of infertility. Thus, they show that this biomedical practice is not a neutral practice based on objective scientific 'facts'. Biomedical practices appear to be informed by interests and power, medical explanations are based on normative ideas, and can result in blaming people, especially women, for fertility problems. In addition, practitioners construct different moral categories of infertility patients, which affect access to infertility services.

However, with the exception of Inhorn's (1994) work, these studies of medical practice and practitioners' categorisation work tend to focus on the west, and on assisted reproductive technologies. Hence, little is known about the social, normative and moral nature of less 'high tech' biomedical *and* indigenous practice in non-western countries.

2.5 Conclusions and exposition of the lacunae in the literature

The literature on infertility then, shows that infertility in sub Saharan Africa is a serious public health problem, given its considerable secondary infertility rates, its relation to STDs, and its many negative psychological and social consequences. Hence, infertility is not only a medical problem but also a problem of a fundamental social, normative and moral nature. There are limited possibilities to solve fertility problems in sub Saharan Africa. Nevertheless, use of indigenous and biomedical

health care for infertility is common, and infertility clients can place a considerable demand on health care systems.

There are several omissions in the infertility literature (section 2.5.2). As they are related to methodological features of the studies, I will review these first (section 2.5.1).

2.5.1 Review of methodological features

The literature review shows that both quantitative and qualitative methods of data collection are used in infertility studies. Quantitative methodologies are used in epidemiological and demographic studies, which rely on large scale surveys, sometimes combined with medical investigations. Studies of psychological correlates of infertility also use quantitative methodologies: questionnaires, and, more frequently, psychometric assessments. Qualitative methodologies are used in ethnographic studies, which draw mainly on interviews and observations.

Studies tend to analyse data at the level of the individual or the collective. In studies of psychological correlates of infertility, the level of analysis is the individual. Responses to questionnaires or psychometric tests are used to make inferences about individuals' psychological states and cognitive processes.

In epidemiological and demographic studies, the level of analysis is the collective, that is aggregates like nations or geographical regions. Thus, individuals' responses to survey questions and outcomes of their medical assessments are aggregated and, through calculation of averages and correlations, inferences are made about the profile of certain infertile populations. In ethnographic studies, the level of analysis is usually the collective as well; observed patterns in statements in interviews are seen as indicators of perceptions and experiences characteristic for a cultural or ethnic group. In some ethnographic studies, like Riessman's (2002, 2005), the level of analysis can be best described as individuals-in-context, as they focus on how individuals can 'work on' and modify socio-cultural circumstances and meanings.

Overall then, infertility studies consider responses to questionnaires, psychometric tests or interviews as pathway to either an underlying, internal reality of individuals' psychological states and cognitive processes, or to an external reality,

for instance regarding behavioural and demographic characteristics of certain infertile populations, or cultural meanings, experiences and perceptions of infertility. In epistemological terms, overall, data are examined from a realist perspective[17]. Ethnographic studies acknowledge that the perceptions and experiences of infertility are culturally specific, and therefore acknowledge that there is a multitude of realities of infertility, which are thus socially constructed. However, the construction work is considered to take place outside the interviews, as interview statements are treated as rather straightforwardly representing the cultural realities. Some ethnographic studies, like Riessman's (2000a, 2000b, 2002), move away from a realist perspective, by considering interview statements as a site where people do work. Riessman (op cit.) for instance examines how women with fertility problems establish a positive gender identity for themselves in interviews.

2.5.2 Lacunae in the literature

The review of the infertility literature and methodological features of infertility studies, shows that there are certain gaps in the literature, which my study addresses.

First of all, no study has yet examined views of people in Malawi on infertility, its causes, consequences and solutions. Nevertheless, Malawi's infertility rates are considerable, and as explained in the introduction, infertility can be expected to be a significant public health issue in this country. Thus, my study will address this gap in the literature by examining local views, or more specifically, constructions, of infertility in Malawi.

Second, infertility studies tend to exclude certain social actors, such as men and significant others, that is people who have a close relationship with people with a fertility problem, like relatives or friends. In addition, whereas some studies describe biomedical and indigenous healing practices in relation to infertility, an in-depth examination of practitioners' views is missing. The lack of attention to the views of certain social actors in studies of infertility seems problematic because of the fundamentally *social* nature of infertility and its management. This highlights the need for examining the views of all social actors involved. My study addresses this

[17] I consider epistemological perspectives as positions on a continuum rather than absolute distinctive stances (Willig, 2001).

shortcoming as it includes a wide range of social actors: women *and* men with a fertility problem, significant others of people with a fertility problem, biomedical practitioners and indigenous healers. I discuss in detail data from interviews with all of these categories of respondents.

Third, in general, infertility studies have treated talk as a *resource* for gaining access to an underlying reality concerning issues related to infertility, but not as a *topic* in itself. Overall, studies have not examined in detail *how* people talk about infertility. As discourse analysts have shown, such detailed examination brings out variability in talk. Variability in people's statements is to be expected, as any phenomenon can be described in a multitude of ways (Potter & Wetherell, 1987; Schegloff, 1973). Potter and Wetherell (1987) point out that social scientists are able to ignore variability in their data because they use various methodological strategies which suppress it. These strategies can be identified in infertility studies as well. A first strategy is restriction (Potter & Wetherell, 1987). Participants in quantitative studies which use surveys or psychological assessments, have to answer in terms of a limited, fixed set of predefined categories. They cannot change the opinions which they express, and any contradictions in answers are ironed out by allocating responses to one particular category only or by discarding these as 'invalid' responses (Wooffitt & Widdicombe, 1996). Second, qualitative studies use 'gross categorisation' (Potter & Wetherell, 1987). Ethnographic studies tend to use a form of thematic analysis, in which responses are clustered together in broad analytic themes. This clustering tends to be based on broad commonalities in content between responses, and responses which differ from the 'average' response are likely to be excluded. As a result, variability between responses is suppressed.

Acknowledging the natural variability in talk problematizes treating it as a resource to access underlying realities (Potter & Wetherell, 1987). It becomes difficult to see what 'reality' statements represent, in part because this requires that one decides which statements are truthful, accurate representations, and which are misguided (*op cit.*). Potter and Wetherell (1987), and many other discourse analysts drawing upon their work, have shown that if one examines variability in language use, in particular how variability in content and form of statements relates to the contexts of their use, insight can be obtained into how statements *function*.

However, the context in which statements occur has not been given sufficient attention. Studies of psychological correlates of infertility ignore context, treating statements as resulting from, and representations of, an individual's mind and mental state. Epidemiological, demographic and especially ethnographic studies take into account context, but only in terms of the macro, cultural context; statements are seen as, in some way, reflecting cultural realities. With the exception of Riessman's (2002), studies have not examined statements about infertility at the level of the interaction, and looked at how statements about infertility relate to, and depend on the local, interactional context. Nevertheless, as I will discuss in the next chapter, a multitude of discourse and conversation analytic studies have shown that the interactional context is highly relevant for what people say and how these sayings should be interpreted.

Thus, the omission to treat talk about infertility as a topic in itself, means that in infertility studies not enough attention is paid to variability in statements, the context in which statements occur, and the function which they fulfil. These are significant shortcomings also because it has been argued that verbal interactions are a central site for the management of social, normative and moral issues (Bergman & Linell, 1998), which appear pertinent to infertility in the developing countries like Malawi.

Riessman's (2000a, 2000b, 2002) work is an exception, in that she pays more attention to the details of interview talk than other researchers of infertility have done. She uses narrative analysis, which treats stories as ways in which people impose order on, and make sense of, experiences and events in their lives (Riessman, 1993). Narrative analysts have a particular interest in gaining insight into how people use narratives to construct their identities (Riessman, 1993, 2002). Thereby they examine content *and,* to some extent, form of the stories which people tell about certain events. Riessman (2000) also pays attention to the interactional context in which interview statements and stories are provided. However, she does not examine talk and its interactional context at the same level of detail as conversation analysts and discourse analysts inspired by it. For instance, she does not always quote the questions respondents are asked in her interviews, making it impossible to discern whether and how the wording of the question matters for the responses.

A final, fourth gap in the literature is that analyses tend to be based on pre-conceived analytical categories and interests rather than on participants' own understandings and orientations, as displayed in their statements. I have explained how epidemiological and demographic studies work from an etic perspective, amongst other reasons due to the use of definitions of infertility which are not grounded in meanings and concerns of the people they study. In addition, the use of survey data, which requires categorisation of responses in pre-established analytic categories, leaves little or no room for analysis of the concerns which participants bring to bear (cf. Wooffitt & Widdicombe, 2006). Studies of psychological correlates impose perhaps even more strongly analytic categories, by using psychometric tests to assess responses in terms of psychological concepts such as 'denial', or 'state anxiety'.

Ethnographic studies of infertility in the developing world are usually of a qualitative nature. It is normally seen as characteristic for qualitative methodologies that they are 'bottom up', of an open nature, and able to bring to the light people's own perspectives (Willig, 2001). However, the extent to which analysis is based on participants' rather than the analysts' concerns depends both on the kind of data collected *and* on the way data are analysed. The thematic analysis which ethnographic studies tend to use, employs as said earlier, a form of gross categorisation (Potter & Wetherell, 1987); statements are collected together in categories, deemed relevant by the analyst, but not necessarily by participants. This is illustrated by the way statements about causes are treated. As mentioned, these are often categorised as personalistic or naturalistic and commonly evaluated for their similarity to or dissimilarity from biomedical knowledge. Such analysis then, is clearly based on analysts' concerns, rather than participants'. Some studies like Riessman's (2002, 2005) suggest an alternative approach to causes, which seems more based on participants' orientations: statements about causes can also be examined for the functions which they fulfil for the respondents, for instance in the negotiation of identities and stigma. However, note that also Riessman's analysis is led by her analytic categories. Due to narrative analysts' special interest in positioning and identity work, Riessman (2002) tends to treat statements invariably as indicators of identity work, regardless of whether identity issues are oriented to by

participants. The form of discourse analysis which I use is particularly disciplined in basing analytic claims on orientations, observably displayed by participants. I will discuss this issue further in chapter 3.

2.5.3 Conclusion and research questions

In conclusion, my study addresses several lacunae in the literature by examining infertility in Malawi, and by including a wide range of participants; men and women with a fertility problem, significant others of people with a fertility problem, Malawian and expatriate biomedical practitioners and indigenous healers. It treats talk about infertility as topic in itself and examines, from a constructionist perspective, the variable ways in which people construct infertility, its causes, consequences and solutions. The unit of analysis is accounts-in-interaction: I will inspect how statements and constructions respond to the interactional context.

Thus, my doctoral research, presented in this thesis, aims to answer the following research questions:

1. How do the various participants construct infertility in Malawi, its causes, solutions and consequences?
2. Which interactional or interpersonal functions[18] do these constructions fulfil?

In addition, both the empirical literature on infertility in developing countries and initial analysis suggested that infertility is infused with normative and moral issues. Therefore, a third research question emerged:

3. If any, what kind of normative and moral issues do respondents attend to and manage in talk about infertility?

In the next chapter, I will describe the methods used to answer these questions.

[18] 'Interactional' and 'interpersonal' functions of descriptions and constructions are intertwined, and there is no clear black and white distinction between them.

Chapter 3. Methodology

In order to examine how people in Malawi construct infertility, its causes, solutions, and its consequences, and how they thereby deal with interactional and interpersonal issues, I use the analytic approach of discourse analysis (DA), informed by conversation analysis (CA). As I will explain (section 3.1), both DA and CA have their roots in ethnomethodology, and share a particular perspective on how people use language to collaboratively accomplish social actions, whilst drawing on shared cultural understandings and ways of making sense. However, DA and CA differ as well. I will explain that my study diverges from CA in terms of its topic, the kind of social actions it focuses on and the type of data used. In addition, I will argue that DA and CA are particularly appropriate methods of analysis to study constructions of infertility, as they have proven to be useful tools to examine the interactional management of various normative and moral issues, which appear central to infertility. In section 3.3, I will discuss the process of data collection, describing first the pilot study which I conducted, and then the main study. Data collection resulted in recordings of 62 interviews, at times mediated by interpreters. I describe the process of analysis in section 3.4. The kind of data which I used is unusual within DA and especially CA, and raises certain methodological issues, which I will introduce in section 3.5. I will end the chapter with a summary of the main analytic themes which arose from preliminary analysis.

3.1 Analytic framework: Discourse analysis, informed by conversation analysis

3.1.1 Ethnomethodology and conversation analysis

Conversation analysis is normally seen as having sprung from, or as a form of, ethnomethodology (ten Have, 2004). Ethnomethodology (EM), initiated by the sociologist Garfinkel (1967a), examines how people interpret and produce social actions in a way that they become accountable, that is 'nameable' and 'intelligible' (Garfinkel, 1967a; Heritage, 1984). Put differently, ethnomethodology is interested in the methods which members of socio-cultural collectivities use to accomplish

orderly and intelligible social actions (Garfinkel, 1974; ten Have, 2002). In principle, any social action or social 'fact' can be examined for how it is accomplished; examples are the formation of queues (Livingston, 1987), decisions made by juries (Garfinkel, 1967a), sex-change (Garfinkel, 1967a), or laboratory work (Lynch, Livingston & Garfinkel, 1983). Ethnomethodological studies use various kinds of data, such as observations (Lynch, 1985), recordings of naturally occurring speech (ten Have, 2001; Maynard, 2003), recorded interviews (Wieder, 1974), or audiovisual recordings (Heath, 1986).

Ethnomethodologists have drawn attention to various characteristics of social action. First of all, as my initial description of EM indicates, social actions and social 'facts' are seen as situated concerted accomplishments, actively and continuously produced by cooperating social actors (Garfinkel, 1967a; Heritage, 1984). This means that social actions should be examined *in situ*, that is in concrete (inter)actions, rather than explaining them by means of abstract general theories or analytic concepts.

Second, this production of intelligible, social actions, is seen as based on culturally shared, taken for granted expectations and understandings, or 'methods of inference' (Garfinkel, 1967b; Heritage, 1984). For instance, ethnomethodological studies have shown how coroners accomplish a judgement like 'suicide', by interpreting various observations (e.g. time of death, medicine bottles, information about financial debts), in a reasonable or 'accountable' way (Garfinkel, 1967b, Atkinson, 1978). Thereby they rely on culturally shared common sense expectations and understandings, for instance about 'typical' circumstances of suicide, and 'typical' people who commit suicide (Garfinkel, 1967b, Atkinson, 1978).

A third characteristic of the production of social action which ethnomethodologists have drawn attention to, is its normative nature. Social actors *ought* to rely on culturally shared expectancies and understandings in the interpretation and production of social actions, in order to be seen as normal, competent members of a cultural setting (ten Have, 1999; Garfinkel, 1967a). Garfinkel (1963, 1967a) demonstrated this in his famous 'breaching experiments', in which students were asked to behave in abnormal, unexpected ways. For instance, students were asked to demand in ordinary conversations for the explication of

ordinary, common sense remarks. An example of such an interaction between a student (S) and participant (P) in the 'experiment' subject, is displayed below.

Example 1

P How are you?

S How am I in regard to what? My health, my finances, my school work, my peace of mind, my….?

P (red in the face and suddenly out of control). Look! I was just trying to be polite. Frankly, I don't give a damn how you are. (Garfinkel, 1967, p. 44)

Garfinkel (1967a) reports two common reactions to the breaching experiments. First, as in example 1, subjects often become confused and angry, and require an explanation for the abnormal behaviour. A second, equally common, reaction was that subjects normalized the students' behaviour by treating it as instances of 'normal', intelligible events. For instance, abnormal behaviour was attributed to the fact that the students had been working too hard, or were ill.

Both reactions show that social actions are treated as the result of actors' accountable moral choices, which can become sanctionable, although not easily unexplainable, if they are not in accordance with common sense expectations and understandings (Garfinkel, 1967a; Heritage, 1984; Hutchby & Wooffitt, 1998).

It is important to realize that the EM perspective on social actions as concerted *accomplishments* is very different from a common approach to social action as governed by social rules or norms (Hutchby & Wooffitt, 1992). Garfinkel (1967a, p.68) criticised this more traditional approach for turning people into 'judgemental dopes of a cultural or psychological sort, or both', as it does not sufficiently acknowledge human agency and knowledgeability in the production of social actions (Hutchby & Wooffitt, 1998)

These ethnomethodological ideas regarding social action have been incorporated into conversation analysis (CA), developed in sociology by Sacks (1974; 1992), who worked together with Garfinkel (Garfinkel & Sacks, 1970). CA can be described as the study of the sequential organisation of talk-in-interaction. A first EM principle which is central to CA is an interest in how social actions are

accomplished. However, unlike EM, CA focuses exclusively on social actions which are produced in talk and inherent to the organisation of conversations, such as opening and closing topics, repairing others' speech, and agreeing or disagreeing with assessments. The decision to focus on talk was based on pragmatic considerations: talk can easily be recorded, and can therefore be subjected to detailed analysis (Sacks, 1992). At the same time, talk seems a particularly appropriate site for the study of social action, as so much of the business of social life is conducted through talk (Hutchby & Wooffitt, 1998, Wooffitt, 2005).

A second ethnomethodological notion which CA has incorporated is that interaction partners rely on shared, taken for granted expectations and methods of inference in the production of orderly, intelligible talk. Third, these expectations and methods of inference are of a normative nature (Heritage, 1984; Hutchby & Wooffitt, 1998), as is demonstrated for instance by the concept of adjacency pairs (Schegloff & Sacks, 1973). Conversation analysts have pointed out that certain utterances tend to come in pairs, and are expected to do so. Examples are questions and answers, greetings and return greetings, invitations and acceptance or rejection. When the first part of these adjacency pairs is provided (e.g. question), the second part (answer) is expected and 'due'. In addition, a second part is normally provided relatively quickly, without any significant gap between the two turns. Example 2 shows that conversation partners attend to this normative organisation, and rely on it as a resource for interpretation.

Example 2.

1. A So I was wondering, would you be in
2. your office on Monday (.) by any chance
3. (2.0)
4. A Probably not.

(from Levinson, 1983)

As A asks a question (lines 1-2), an answer is the normatively expected next turn. In this case, an answer is not immediately forthcoming: there is a two second pause (line 3). Therefore, A infers trouble of some sort: the pause is taken to project a negative response, as shown by 'probably not' (line 4). Thus, the expectation that a

question is followed by an answer serves as source of interpretation for a pause following a question.

This example demonstrates as well the relevance of a fourth ethnomethodological notion regarding social actions and talk, namely their *indexical* nature. This means that the meanings of utterances and actions are dependent on the specific context or situation in which they are used (Potter & Wetherell, 1987). In example 2, the silence, or the absence of an action –an answer- becomes meaningful because it occurs in the context of a question which was asked in the previous turn.

A fifth characteristic of social actions, pointed out by ethnomethodologists and taken up in conversation analysis is their *reflexive* nature. Verbal and nonverbal actions continuously (re)constitute the meaning and nature of the situations in which they occur and of previous actions in those settings (Garfinkel, 1967; Pollner, 1991)[19]. Consider the examples of two interactions displayed below.

Example 3

A The washing up needs to be done soon
B I'm sorry, I was going to do it earlier

Example 4

A The washing up needs to be done soon
B Okay, I'll do it.
(from Antaki, 2000)

In example 3, B responds to A's statement with an apology: 'I'm sorry'. In so doing, B makes A's statement into, and constitutes its meaning as, a complaint. In example 4, however, B's response 'Okay, I'll do it', makes A's utterance into a request.

The acknowledgement that talk is indexical and reflexive points to CA's specific interest in the *sequential* organisation of talk. From a CA perspective, sequences are essential to the accomplishment of meanings and actions in, and thus organisation of, talk-in-interaction. This is so because, as the examples provided

[19] Note that in principle, the notion of reflexivity implies that all sense-making, including academics' is a constitutive process, and can be analysed as such. Pollner (1991) urges analysts to consider their own analyses as accomplished productions, which make the world 'seeable sayable' (Garfinkel, 1967a). This kind of 'radical reflexivity' (Pollner, 1991) got lost in more recent ethnomethodological work, and especially in CA. It is more present in discourse analytic work, and I acknowledge the constructed and constructive nature of my work as well, as I will discuss, to some extent, in this thesis' discussion.

show, in every turn, a speaker inevitably displays, implicitly or explicitly, his or her understanding of what 'prior' turns are about. Whether or not the original speaker agrees, or goes along with that interpretation, is demonstrated in the next, third turn (Hutchby & Wooffitt, 1998; Heritage, 1984; Schegloff & Sacks, 1973). Thus, speakers construct the sense of a situation together on a turn-by-turn basis (Heritage, 1984).

Whilst the majority of CA deals with explicating the sequential organisation of talk, another theme can be discerned: analysis focussed on the use of membership categories (Sacks, 1992; 1972). Especially in his early work, Sacks dealt with the EM concern of people's shared common sense knowledge, as used in interactions. Sacks (1972) noted that this knowledge is organized, in part, in terms of categories of people, such as 'mother' or 'husband'. According to common sense, these categories are part of sets of categories, which are called Membership Category Devices (MCD, Sacks, 1972). An example of a MCD is 'family', which contains categories such as father, mother, son, and daughter. Categories are associated with category predicates, such as category bound activities; these are activities which members of categories are common sensically expected to perform. For instance, mothers are expected to pick up crying babies. This makes categories inference-rich: mentioning a category invokes a range of expectancies about the attributes of that category, for instance in terms of knowledge, rights and normal activities. Whilst attention for membership categories has receded into the background in 'mainstream' CA, it has been picked up by others and developed into 'Membership Category Analysis' (Hester & Eglin, 1997). In my study, I pay attention to the use of membership categories as well as to the sequential organisation of talk. However, like Schegloff (2007), I consider 'MCA' as integral part of CA, albeit a part which deserves more attention (Watson, 1997; Silverman, 1985). The analysis of culturally shared common sense knowledge, for instance regarding membership categories, needs to go hand in hand with attention to its situated use within sequences (Watson, 1997).

3.1.2. Discourse analysis, informed by conversation analysis

There are many different kinds of discourse analysis (DA) (Wetherell, Taylor & Yates, 2001)[20]. The form of DA which I use in my doctoral research originated in the sociology of scientific knowledge (Gilbert & Mulkay, 1984), and was developed in social psychology (Potter & Wetherell, 1987). More recently, it has grown into what has been called discursive psychology (DP, Edwards & Potter, 1992, 2003; Edwards, 2005; Wiggins & Potter, 2007). Although my approach can be seen as one form of DP, I find it more useful to describe it as 'discourse analysis informed by conversation analysis'. I will outline the reasons for my choice of this descriptor below.

The kind of DA which I use has various sources of inspiration; Wittgenstein's Philosophical Investigations (1953), Austin's (1962) speech act theory, and in particular ethnomethodology and conversation analysis (Edwards, 1995, Potter, 2005; Wooffitt, 2005). [21] It relies on two main conversation analytic and ethnomethodological principles. First, DA informed by CA treats talk as social action (Wooffitt, 2005). Descriptions are seen as reflexively constructing realities and versions of events, rather than as passive pathways to reality, whether of an external (e.g. situations and events), or internal (e.g. attitudes, beliefs, or cognitive processes) kind (Edwards & Potter, 2003). In addition, talk is seen as action, in that descriptions are seen as fulfilling certain interactional and interpersonal functions, like disclaiming responsibility or justifying.

Second, this form of DA pays increasing attention to the sequential organisation of talk, and how this organisation is infused with expectations about what turn should come next (Edwards & Potter, 2003; Potter, 2005). It thus treats talk and the actions it performs as a concerted accomplishment, rather than as a product of isolated, single minds.

The emphasis on talk as social action, and the treatment of statements as constructive rather than as pathways to an internal or external reality, has been used

[20] See footnote 22 for a description of another form of DA, inspired by Foucault's work.
[21] Commonalities can be identified as well between Austin's and especially Wittgenstein's work, and ethnomethodology and conversation analysis, for instance with regard to a focus on language use, language use as social action, and meanings being dependent on the context of their use. However, in literature on CA few references to Wittgenstein and Austin can be found, and Sacks' approach to social actions is more often seen as 'truly original' (cf. Wooffitt, 2005)

to develop a discursive psychology, in reaction to the dominance of 'cognitivism' in psychology (Potter, 2000; Willig, 2001). Psychology is dominated by approaches which study cognitive processes and mental, individualistic concepts like 'attitudes', and treat them as causes of social action (Willig, 2001; Potter & Wetherell, 1987; Potter, 2000). Discursive psychology aims to shift the focus from individualistic cognitions and processes to social interaction (Hepburn & Wiggins, 2005).

This particular DA tradition deals with several, overlapping, themes (Edwards & Potter, 2003b; Hepburn & Wiggins, 2005). First, authors have dealt with respecification and critique of traditional, cognitive psychological concepts, such as attitudes or beliefs (Potter & Wetherell, 1987), causal attribution (Edwards, 1991; Edwards & Potter, 1993) and cognitive scripts (Edwards, 1994; 1997). These psychological notions are respecified as situated, discursive practices (Edwards & Potter, 2003; Hepburn & Wiggins, 2005), by means of examination of how they are constructed and addressed in talk and text, and the interactional, interpersonal functions which they thereby fulfil. Second, studies have focussed on common sensical, everyday usage of terms from the 'psychological thesaurus', such as 'anger' or 'upset' (Edwards, 1999, 2005). A third main theme is the, often implicit, management of 'psychological business' (Edwards, 2005, p. 259) such as motives, intentions and agency. This strand of research focuses on how descriptions are used to implicate psychological states (Edwards, 2005). Particular attention has been paid to the relationship between the construction of facts and reality, and management of accountability, stake and interest (Potter & Edwards, 1992; Potter, 1996; 2004). Fact construction is also examined for how it is used in the management of other issues, which are often of an ideological or political kind, such as racism and prejudice (Tileaga, 2005; Whetherell & Potter, 1992), sexism (Speer & Potter, 2000) or gender and sexuality (Speer & Potter, 2000).

DP's concentration on reworking the subject matter of psychology (see e.g. Edwards, 2005; Wiggins & Potter, 1997; Wooffitt, 2005) is one reason why I adopt a different term for the analytic framework of my doctoral research. Although my analysis is related to various classic psychological topics, such as attributions and (health) beliefs, it is of relevance to traditional sociological topics as well. For instance, in chapter 4 I deal with the issue of cultural norms, and how they are

worked up by respondents. In chapter 6, I discuss how respondents attend to normative expectations as specified in Parson's classic (sociological) concept of the sick role. Categorizing one's approach as discursive *psychology* implies a commitment to study phenomena traditionally studied by psychologists, and this leads in my opinion to an overly restricted analytic focus. In addition, it seems at odds with the CA maxim that analysis ought to be based on concerns and categories as made relevant by participants in the data (Schegloff, 1992, 1997), and should not be stipulated by analysts' disciplinary and theoretical interests and concepts.

Second, I prefer to use the term 'DA, informed by CA' for my approach because it is more methodologically informative; it makes explicit that this is an approach which uses a combination of discourse analysis and conversation analysis. 'Discursive psychology' suggests a focus on discursive and psychological phenomena, but does not delineate the methodology used to study them. This cannot readily be inferred from the existing body of DP studies either. Whilst the more recent DP studies draw heavily on CA findings and principles, older work in this area (Edwards & Potter, 1992) pays notably less attention to fundamental CA interests, such as the sequential organisation of descriptions. One reason for this is that some older DP work uses textual data, or conversations which are not transcribed at the CA level of detail.

Third, key authors in DP have increasingly adopted CA's dispreference for interview data (Potter, 2004; Wiggins & Potter, 2007). As Wiggins and Potter (2007) state: 'discursive psychology is distinct from the earlier tradition of discourse analysis in almost completely abandoning open ended interviews as a research method'. My own PhD study however is based on interview data, and I adopt a more favourable stance towards this kind of data, whilst acknowledging that there are certain issues involved (see section 3.4.1)

3.1.3 Differences between discourse analysis and conversation analysis

In addition to commonalities between CA and DA, differences between the two traditions can be identified, and this is where my analytic approach diverges from conversation analysis. It should be noted however, that most of these differences are relative rather than absolute.

First, CA and DA tend to differ in terms of their research topics (ten Have, 2005; Widdicombe & Wooffitt, 1995; Wooffitt, 2005). CA focuses on the organisation of talk-in-interaction. This is often done by examining (telephone) conversations about mundane topics (ten Have, 2005; Wooffitt, 2005), like selling fruitcakes, although attention has been paid as well to talk in institutional settings, such as courtrooms (Atkinson & Drew, 1979) or medical consultations (Frankel, 1984; ten Have, 2001). Discourse analysts have dealt more often with topics which seem, at least at first sight, of greater social or political relevance, such as racism (Wetherell & Potter, 1992), politics (Potter & Edwards, 1990), and controversial chronic illness, like chronic fatigue syndrome (Horton-Salway, 1998; Guise, 2004). Thus, in terms of its topic, my study is more in line with DA than CA, as I focus on an issue of great social, and public health, relevance: infertility in Malawi.

A second difference is related to this difference in topics studied: DA focuses on other sorts of social action than CA (Wooffitt, 2005). Overall, CA is more interested in actions inherent to the management of conversations, such as turn taking, opening or closing down of a topic, repairing speech. Discourse analytic studies like mine, look at broader interpersonal functions (Wooffitt, 2005), such as justifying, blaming and forestalling accountability or problematic identity attributions.

Third, whilst CA is focussed on the analysis of sequences and turn organisation, DA is more interested in accounts and descriptions, although it examines these within their sequential context (Wooffitt, 2005). In other words, in much CA work, explicating the sequential organisation and management of conversations is an end in itself. However, in DA studies, like mine, examination of the sequential organisation and the interactional context is a means to an end: it is necessary in order to gain insight into the construction of versions of events, actions and situations, and the kinds of inferential and interactional issues people thereby manage.

Fourth, DA differs from CA in that it is interested in both the sequential *and* rhetorical organisation of talk (Edwards & Potter, 2003; Potter, 2004). DA has an interest in how people's descriptions or versions of reality are designed to be

persuasive and to counter actual or potential alternatives, as well as forestall being undermined as partial, biased and interested (Potter, 2004).

Fifth, there are differences regarding the type of data used. CA relies exclusively on naturally occurring speech, whereas DA is more eclectic and uses for instance interview data or policy documents. I have conducted interviews for my doctoral research, and will discuss this choice further in section 3.3.

Hence, my approach diverges from CA because of its use of interview data, a focus on accounts in their interactional context, rather than on the sequential organisation per se, and an interest in social actions which go beyond those pertaining to the organisation of conversations. This has certain methodological implications. Although I pay attention to the sequential positioning of statements, my analysis does not lead to a systematic explication of in which position certain actions tend to be performed, as CA studies typically do. In addition, I have not transcribed my data in as much detail as would be required for CA, or contemporary forms of DP As a result, I have paid less attention to paralinguistic details such as pauses and overlap than conversation analysts normally do. My decision to use a less detailed form of transcription was largely based on pragmatic considerations; the quality of my recordings is sub-optimal, largely because many interviews took place outside or in buildings, which were all but sound proof. In addition, detailed transcription of the exchanges in local languages, and of their translations, was not feasible. Furthermore, that analysis at a higher level of detail was not essential due to my interest in accounts and their interpersonal functions rather than in the mechanisms of conversation.

Having described my analytic approach, I will explain in the next section why this approach is particularly apt for the study of constructions of infertility.

3.1.4 Normativity and morality in discourse and conversation analysis

As discussed in the literature review (chapter 2), ethnographic studies of infertility show that the problems which infertility involves for people in developing countries are of a fundamental interpersonal, moral and normative nature. Infertility leads to various interpersonal issues such as blaming, social exclusion and other relational troubles. In addition, it appears to be especially problematic due to ingrained ideas

about what 'ought' to be (e.g. married men and especially women ought to bear a significant number of children) and what is good and bad (e.g. not bearing children is bad). CA, and DA informed by CA, are particularly useful tools for gaining insight into such issues.

Various scholars have argued that normativity, morality and social (inter)action are deeply interrelated (Bergmann, 1998; Garfinkel, 1967; Goffman, 1959; Heritage, 1984; Shotter, 1991, 1993). Two levels can be identified at which they are intertwined (Bergmann, 1998, Heritage & Lindstrom, 1998). First of all, at a fundamental, basic level, there is the moral and normative nature of interaction itself. I have discussed how a central ethnomethodological notion, picked up by conversation analysis and discourse analysis, is that orderly, intelligible social action is dependent on people's orientation to normative understandings and expectations. Interaction is infused with obligations and rights, such as those regarding who can speak next and regarding what next turn is appropriate (Heritage & Lindstrom, 1998)

A second 'level' at which morality and normativity are intertwined is what Heritage and Lindstrom (1998) call morality *in* interaction: moral activities are often 'done' in talk-in-interaction, either explicitly or implicitly. Drew (1998) even argues that descriptions may always be understood as doing moral work, in that they provide a basis for the rightness or wrongness of conduct. There is a large body of CA studies, and DA studies which draw upon CA, which discuss in detail the management in talk of various normative and moral issues, such as attributions of responsibility and blame (Pomerantz, 1978; Watson, 1978; Sneijder & te Molder, 2005), accusations (Drew, 1984), justifications (Pomerantz, 1986), and complaints (Drew & Holt, 1988; Pomerantz, 1986). Some studies focus more specifically on normativity, in that they examine and discuss how people accomplish deviance (Hester, 1998) or normality (Pomerantz, 1986; Sacks, 1984; McKinlay & Dunnett, 1998).

These studies provide various insights into the management of normative and moral issues in talk. To begin with, they have identified various discursive devices, or conversational 'building blocks' , which are used in the production and management of moral and normative activities. For instance, in their study of internet discussion groups on veganism, Sneijder and te Molder (2005) show how if-then

constructions can be used to allocate responsibility and blame for (ill) health. They argue that discursive constructions like 'if you do x, then problem y will not arise' suggest that problems can be avoided by people's own actions, and thus make people themselves to blame for health problems.

Drew (1998) examined complaints of misconduct. He found that the misconduct which is complained about, is often what the other said to the complainant, who reports this through quoting speech. In addition, Drew (1998) notes certain prosodic features of this reported speech which convey a 'deprecating, insulting tone' or a 'mock innocent tone'. Such prosody, Drew (1998) argues, plays a role in displaying the untoward moral character of what was said. Drew (1998) finds that reported speech is rarely followed by an explicit evaluation, and argues that the reported speech enables the recipient to appreciate how rude, unjust and thoughtless the other was, without the complainant needing to categorize the offence.

Pomerantz (1986) notes that when people are engaged in moral activities, like complaining, blaming and justifying, 'extreme case formulations' (ECFs) are common. These are formulations which evoke the maximal or minimal properties of an event or action (Hutchby & Wooffitt, 1998). Examples are 'never', 'every time', 'everyone'. Pomerantz (1986) suggests that these ECFs are particularly useful when engaging in moral activities such as making complaints. ECFs can be used to offer the strongest case of the 'offence' complained about and thereby forestall that an offence committed is dismissed as minor (op cit.). In addition, ECFs can be used in the justification of actions and their actors, as they can display an action or situation as omnipresent and thereby used to propose the rightness of a practice. To illustrate this, Pomerantz (1986, p. 225) reproduces an example which Sacks gave in one of his lectures, which concerns a call to a suicide prevention centre. The caller has just confirmed that she has a loaded gun at home.

Desk What is it doing there, hh Whose is it.
Caller It's sitting there.
Desk Is it yours?
(1)
Caller Its Da:ve's
Desk It's your husband's huh?=
Caller =I know how to shoot it,
(0.4)
Desk He isn't a police officer:r

Caller No:
Desk He just ha:s one
Caller Mm hm, It- u- everyone doe:s don't they?

Pomerantz points out that, by saying 'everybody does', the speaker proposes that having a gun is a normal and accepted practice. The speaker thereby relies on a shared assumption that how other people behave is the 'right' way to behave and not accountable. Buttny (1994) also notes how couples in relationship therapy can display themselves as behaving like other people do, and thereby normalize their behaviour and forestall the inference that their behaviour is cast as blameworthy.

McKinlay and Dunnett (1998) too, discuss how gun-owners establish normality, and identify contrast structures as a discursive device. McKinlay and Dunnett (1998) note how a member of the National Rifle Association of America contrasts members of the association with criminals and vigilantes. In so doing, members of the rifle association are portrayed in a favourable light, that is as average, law-abiding citizens, and being a gun-owner is normalised. However, Smith (1978) has shown how contrasts can also be used to establish *deviance* rather than normality. In her study of 'K is mentally ill', Smith (1978) shows how by presenting K's activities as a contrast to an implied norm of behaviour, K's behaviour is established as anomalous, and as an instance of pathological behaviour.

In addition to bringing to the light the various building blocks of moral activities, CA (informed) studies have provided insights into the sequential organisation of normative and moral activities. They have shown in what position in a sequence of turns and activities a moral activity is done, or certain elements are used. For instance, Pomerantz (1978) notes that blamings are often done in the turn *after* a turn in which a speaker reported an 'unhappy incident'. These reports of 'unhappy incidents' can be characterised by the absence of an actor, and do not indicate what or who is responsible for the event. This enables recipients of the reports of 'unhappy incidents' to initiate the attribution of responsibility. Pomerantz (1986) tentatively suggests that this sequential organisation may fulfil a function of enabling a speaker – the reporter of the unhappy incident- to avoid attributing blame to a co-participant who appears implicated in the event. Drew and Holt (1988) noticed that idioms are often used in complaints, and tend to occur after recipients of

complaints have declined the opportunity to affiliate with the complaint. This suggests a non-sympathetic response or reception by the recipient. Hence, Drew and Holt (1988) suggest that idioms are ways in which complainers seek affiliation (op cit).

Furthermore, studies have provided insight into the nature of moral activities as negotiated and sensitive. The moral nature of activities and utterances needs to be worked up, rather than being pre-determined and pre-given (Linell, 1998; Drew, 1998; Watson, 1978). Again, attention is drawn to the reflexive nature of accounts and their action-potential: they do not passively re-present events and activities, but construct what was reported as right or wrong (Drew, 1998; cf. Buttny, 1998). CA and DA studies show that moral activities like blaming and justifying are sensitive activities, in that they are often done implicitly. This is partly because, as Linell (1998) points out, social actors engaging in moral activities risk becoming objects of moral judgements themselves. It is not surprising then, that various authors (Bergmann, 1998; Drew, 1998; Pomerantz, 1978) show that these activities are often done implicitly. Hence, a detailed form of discourse analysis, informed by conversation analysis, appears particularly appropriate for the study of a topic like infertility, which appears infused with sensitive, interpersonal, normative and moral issues.[22]

In the next section, I will describe what kind of data I obtained in order to examine constructions of infertility in Malawi, as well as the process of data collection.

[22] Another form of discourse analysis which is common in psychology is Foucauldian discourse analysis (Willig, 2001). Foucauldian DA is concerned with the identification of wider discourses in societies, such as a 'biomedical discourse', or 'romantic discourse'. It examines the subjects positions made available in these discourses and how they enable or obstruct practices. This type of analysis is less detailled than DA informed by CA, and does not focus on the sequential organisation of actions and meanings and how they are co-produced in situ.Therefore, this approach was not suitable for my study of the management of interpersonal, normative and moral issues in talk about infertility. Moreover, advantages of DA informed by CA are that it offers a tool for validating claims by means of participants' interpretations as displayed in their responses to previous turns, and it avoids problems involved in the reliable and accountable identification of coherent discourses (Wooffitt, 2005; Potter, 2004)

3.2 Data collection

3.2.1 Pilot study

Data collection consisted of two stages: a pilot study and main study. I carried out a six week pilot study in Malawi from May to June 2002, with as main aim to explore the relevance of infertility in Malawi, and to assess the feasibility of the recruitment of participants.

In this pilot study, I conducted and recorded seven semi-structured interviews with Malawian health practitioners (5), an indigenous healer (1), and an indigenous birth attendant (1). In addition, I conducted nine unstructured interviews, with expatriate (4) and Malawian (4) biomedical practitioners and an indigenous healer (1). These interviews were not recorded, but I took detailed notes which I wrote up as soon as possible after the interview. All semi-structured interviews were recorded. Furthermore, I had many informal conversations about infertility with various informants (e.g. academics, community members, missionaries).

The pilot study showed that infertility is indeed a highly relevant and problematic issue for both lay people and practitioners in Malawi, confirmed the feasibility of the study, and led to valuable advice to recruit respondents through health surveillance assistants (HSAs). However, it became clear that I had to broaden the scope of my study. Initially, I had planned to focus on women with a fertility problem, as well as significant others and health practitioners. This was based on the assumption, widely reported in the literature, that women bear the brunt of the problems which infertility involves. However, this assumption was questioned by many informants. Therefore, and because my on-going literature research showed that so far scant attention has been paid to men with a fertility problem, I decided to include men in the main study.

3.2.2 Main study

From June to August 2003 I conducted the main study, which lasted 12 weeks. I will discuss the main study in terms of sampling and recruitment strategies, participants, ethical issues and the interview process.

Sampling strategies

The sampling strategy which I used in the main study can be best described as purposive sampling, as participants were recruited with the purpose of ensuring diversity in mind (Trochim, 2000), although convenience or 'accidental' sampling was used at times as well. I recruited participants from all three regions (North, Central, and South) of Malawi, belonging to various ethnic groups and living in both rural and urban areas. I interviewed both Muslims and Christians, and both people who speak English and those who do not.

As mentioned in the introduction (chapter 1), selection of respondents with a fertility problem was based on whether people see themselves, or are seen by others, as having a fertility problem, *regardless* of number of children and duration of their fertility problem. Consequentially, men and women were recruited who suffered from primary infertility, meaning that they were childless, or from secondary infertility, that is they had one or more children but wanted to have more. The duration of fertility problems experienced varied as well, but most participants had had fertility problems for several years.

The biomedical practitioners who participated worked in different types of rural and urban health services, such as government and mission hospitals, rural health centres, or clinics of Banja LaMtsogolo, a NGO which provides family planning and other reproductive health care. In addition, I recruited practitioners working in various capacities; HSAs, nurses, medical assistants, clinical officers, medical doctors and gynaecologists. Furthermore, I recruited Malawian practitioners, and expatriate doctors, working in Malawi but born and trained in western countries.

I recruited both indigenous healers and indigenous, or traditional birth attendants (TBAs). TBAs provide mainly care for pregnant women, but are also approached for fertility problems. A list of the abbreviations used to indicate the different kinds of participants in the extracts presented in the analytic chapters can be found in Appendix D.

Recruitment strategies

Participants with fertility problems were predominantly recruited in communities, through intermediaries, especially health surveillance assistants (HSAs). HSAs

provide basic health care services to communities, like immunizations and growth monitoring of children under five years old. They were deemed appropriate for recruitment as they are familiar with the people in the communities in which they work, and often live. Other intermediaries were English speaking Malawians whom I encountered during my 12 week stay in Malawi, and who were interested in helping me in my study, like people working in guesthouses and museums. A few respondents (4), were recruited and interviewed whilst they were waiting for their consultation in an infertility clinic. In addition, some of the respondents with a fertility problem were colleagues of practitioners whom I had interviewed.

Because of the recruitment through intermediaries, selection of respondents was inevitably based on others' perceptions of people as having a fertility problem. Indeed, two respondents explained in the interview that they did not consider themselves as having a fertility problem. One respondent used to find the fact that he had three children problematic, but not anymore. I included these respondents nevertheless, as they were seen by others as having a problem: by the intermediaries who recruited them, as well as by family and community members who pressurized them to reproduce.

Indigenous healers and traditional birth attendants were also recruited through health surveillance assistants and other intermediaries. Biomedical practitioners were mainly recruited in hospitals and health clinics, after I had obtained permission from the hospital management, on the basis of a letter of approval from the Malawian Ministry of Health and Population. Expatriate doctors were also recruited through personal contacts I had made in Malawi.

Most significant others were recruited 'accidentally'. They were often English speaking Malawians with whom I got to talk about my study, and who appeared to have a relative or, in one case, a friend with a fertility problem. In addition, in several interviews with both biomedical and indigenous practitioners, the respondent appeared to have a relative with fertility problems. In these cases, respondents were treated as both professional and significant other, and interviews were conducted according to shortened interview schedules for both categories of respondents.

Originally, I intended to record doctor-patient interactions in infertility consultations as well. However, this proved to be not feasible. It was too time consuming, as doctors did not normally know in advance when they would see an infertility client, and recordings would have to be made 'at random'. Another obstacle was a certain professional sensitivity, which has been noted as problem for obtaining professional interactions by others as well (Hepburn & Potter, 2004). For instance, one doctor did not consent to have his interactions with patients recorded as he thought they would not be a representative sample: that day was particularly busy, because of which consultations would be more rushed than normally.

Overall, people were not paid for participation. Instead, they were given small tokens of appreciation; a soft drink, if available, during the interview, and bars of soap afterwards. Two indigenous healers asked to be paid, which I did, as this was one of the more difficult groups of respondents to reach. Interpreters were offered payment for their interpretation, but all HSAs declined a monetary reward. In return for their help, I worked therefore a few times as a volunteer in their under five and antenatal clinics.

Participants

Recruitment resulted in interviews with 66 participants in the main study: 8 men and 14 women with a fertility problem, 7 significant others of people with a fertility problem, 6 indigenous healers, 26 Malawian and 5 expatriate biomedical practitioners working in various functions (see Appendix B). Of this set of interviews, 6 were not recorded. In the case of one nurse and two women with a fertility problem this was because they did not give permission, in one case there was a technical problem. I did not record two interviews with biomedical practitioners, because they indicated to have only time for a very brief 15-minute interview, which suggested to me that I could only get some limited background information from them. In practice however, the interviews took both roughly 40 minutes. In total then, I obtained recordings with 60 participants in the main study.

As the interviews obtained in the pilot study were sufficiently similar to the interviews of the main study, I included them in the analysis.

In total, therefore, I used a set of interviews with 67 participants. Note however that the total number of interviews is smaller than this, since some respondents were interviewed together. Details of numbers of respondents per category of respondents are presented in Appendix B.

Ethics

I designed my study according to the BPS and APA code of conduct, and obtained ethical approval from the Psychology (UoE) ethics committee, as well as from the Ministry of Health and Population of Malawi.

At the start of the interviews, I told respondents what the aim of the study was, and that their anonymity was guaranteed, although expatriate practitioners were explained that as there is a limited number of them in Malawi, there was a small chance that they could be identified. In addition, I told all participants that, since I wanted them to feel comfortable, they should feel free not to answer questions. I also asked for permission to record the interviews, whilst making clear that respondents could ask for the tape recorder to be switched off at any moment. Oral consent was obtained before and after the interview, and respondents were encouraged to ask questions about myself, the interview and the project.

Other ethical issues had to be dealt with as well. These were especially pertinent to the interviews with men and women with fertility problems, due to the sensitivity of the topic, participants' unfamiliarity with social science research, and power differentials between white researchers and participants.

Considering the sensitivity of the topic, I did not interview significant others of the 'infertile' respondents in my study, as this could make people more uncomfortable and could lead to tensions between respondents. For the same reason, I avoided interviewing both the man and woman of a couple experiencing infertility problems. In one case however, a couple insisted to be interviewed together. In another case, both the man and woman were interviewed as the interpreter advised that not doing so would be offensive for the husband.

In general, people were unfamiliar with research interviews, and appeared keen on finding a solution for their fertility problem. Therefore, there was a risk of

creating false expectations regarding the help which I could offer. Therefore, I avoided recruitment of men and women with a fertility problem in hospitals, in order to diminish the chance that I was seen as a type of health practitioner. In addition, I asked the intermediaries who approached potential respondents to make clear that I am not a doctor and would not be able to solve their problem. I emphasized this at the beginning of all interviews as well, and explained that rather than providing immediate practical help, I would write a report for the government about the experiences and views of people with a fertility problem in Malawi, so that policymakers and medical practitioners could take these into account. Respondents were promised a summary of the report. Regardless of my emphasis on the fact that I was not a health expert, several respondents asked for medical advice. In those cases, I repeated my lack of medical knowledge and referred them to the HSA, who was usually present at the interview, or to the health centre or hospital.

Interview process

The interviews were guided by an interview-schedule (see appendix C), designed on the basis of the infertility literature, and the interviews which I conducted in the pilot study. Care was taken that the questions were open-ended, and as non-directive as possible, in order to enable respondents to bring up new, unexpected issues which they themselves saw related to infertility. For this purpose I also included as a final question in the interviews 'is there anything else you would like to tell me, which we haven't talked about yet?'.

The main themes covered by the interview-schedule for people with a fertility problem were their desire and need for (more) children, changes in their relationships with others, ideas about causes of infertility, solutions sought, and expectations and experiences of health services used.

The interview-schedule for significant others covered the following topics: the importance of bearing children for their relative or friend; causes of infertility (in general and regarding their relative's or friend's fertility problem); ideas about solutions sought by their relative or friend; changes in their relationship with their relative or friend; and perceptions of and treatment by community members of their relative or friend.

Biomedical and indigenous practitioners were asked about their experiences of consultations with infertility clients, the main causes of infertility, and about differences in opinion regarding causes with their patients. Practitioners were also asked about how they try to help infertility clients and clients' response to their help, in terms of whether they are satisfied and whether they accept advice. Furthermore, questions address their ideas and opinions about help sought from other sources, and ideas about the importance of bearing children.

I adapted the interview schedule for men and women with a fertility problem after the first few interviews, as some more open and abstract questions tended to result in confusion, or in very brief responses. This was for example the case with the question 'were your relationships with others affected by your fertility problem?'. I made this question more concrete by including examples of specific relationships, with for instance husband or wife, family members or neighbours, and by giving more concrete examples about ways in which a relationship could change, such as 'did people start to treat you differently', or 'do people ever make fun of you'. Note that therefore, questions became at times less open than would be ideal.

In about one-third of the interviews, I used an interpreter; in twelve interviews with men and women with a fertility problem, two interviews with significant others and in all eight interviews with indigenous healers and traditional birth attendants. In most cases, interpreters were the HSAs who helped me recruit the respondents. Before the interviews took place, I discussed the interview-schedule with the interpreters, and checked that they understood the questions. I stressed that I would like the interpreters to translate as literally as possible, that leading questions should be avoided and that everything said in the interviews should be treated as confidential. However, as will become clear when I discuss the analysis, interpreters regularly introduced their own questions, and often made my questions less open in their translations, for instance by giving respondents examples of what the answer could be. I will discuss this active contribution of the interpreters in section 3.4, as well as in the discussion chapter.

Interviews were semi-structured, in that I allowed for the possibility to change the order of topics, and not all respondents were asked the same questions.

This depended on the issues brought to bear, and the time available. Interviews took between 30 minutes and 1.5 hours, with most lasting for slightly over an hour.

All recorded interviews were transcribed; some by myself, others by professional transcribers in order to speed up the process of transcription. I checked all transcripts and refined them according to a somewhat simplified version of the standard CA form of transcription as developed by Jefferson (Hutchby & Wooffitt, 1998, see Appendix D). This means that the transcripts included various paralinguistic details, such as laughter, pauses and overlap between utterances.

As mentioned, for some interviews I used interpreters. For 8 of these interviews with people with a fertility problem and 3 of the interviews with indigenous healers, I obtained translations of the interactions between interpreters and respondents. In addition, I got several additional extracts translated from 8 more interviews, when it appeared that they were candidates for inclusion in the thesis. These translations were necessary, considering that from a CA perspective, meanings and actions in talk are concerted achievements. Translation would thus enable me to analyse essential interactions between interpreters and respondents. Unfortunately however, translations are expensive and therefore the amount of data which I could get translated was somewhat limited.

Data was translated by linguistics students of the University of Malawi and professional translators of the African Language Institute in Leiden. Translators were asked to translate as precisely and literally as possible, paying attention to grammatical forms. They were asked to adjust the word order in order to make the translations more readable. I discuss the methodological issues raised by the use of translation in section 3.3 and in chapter 10.

In section 3.3, I will discuss how I analyzed the interview data which I collected in Malawi.

3.3 Process of data analysis

It has been argued that the process of discourse analysis evades descriptions in terms of steps to take, as it is more a practical skill, comparable to sexing chickens or riding a bicycle (Potter, 2004b; Potter & Wetherell, 1987). Nevertheless, it appears

possible to discern several steps in the process of analysis (Potter & Wetherell, 1987; Potter 2004a; Willig, 2001).

Analysis started with the listening to the tapes during the transcription. As Hutchby and Wooffitt (1998) point out, transcription requires repeated, close listening and detailed attention to the data, and is therefore an integral part of the analysis. A second stage was the reading and re-reading of the transcripts, whilst carrying out provisional coding of the data, which can be seen as a third stage of the analysis. This coding was based on a combination of the content and form of accounts, or the actions which they seemed to perform. I grouped together these codes in data sets, based on the content of the themes addressed in the extracts, such as 'causes', 'consequences' and 'solutions'. For instance, codes such as 'denying disappointment patients' and 'doing being competent practitioner' were kept together in a data set on 'talk about solutions by practitioners'. I choose for grouping together codes in this way as it appeared to form the best basis for a coherent analytic story. Note that my main analytic focus was on actions performed by respondents, but as certain actions tended to occur when cetrain topics were discussed, content became a major organizational principle in the analysis.

In a fourth and central stage, I conducted a more detailed analysis on these sets. Selection of extracts for further analysis was informed by my theoretical interests, and by my impression that some particularly interesting or striking interactional or interpersonal business was being performed. For instance, it struck me that a strong denial of knowledge (i.e. 'I would not know') was a recurrent response to a question about causes of people's fertility problem. This seemed a theoretically interesting topic to explore as it has not been discussed much in studies of infertility or other health problems, which do pay much attention to people's illness beliefs.

The more detailed analysis involved a gradual change away from a focus on content to an explication of the design and sequences of utterances and the actions performed. However, the content of responses remained important. Whilst analysing data, I usually dealt first with one set of participants, for instance biomedical practitioners, and then compared and contrasted this data with data from another set of respondents. This could obviously only be done when similar topics were

discussed. This was useful for identifying both similarities and differences across types of participants, although I avoided the assumption that belonging to a particular category, for instance indigenous healer, would necessarily be relevant for the production of talk.

In the analysis of the data, I adhered to several discourse analytic and conversation analytic principles. First, DA, informed by CA, is data-driven, and based on *participants' understandings and orientations* rather than those of the analyst. This is so because of the ethnomethodological principle that participants' own understandings are central to the production and meaning of their actions (Schutz, 1972). Hence, I have refrained as much as possible from making a priori assumptions about the relevance of analytical theories and categories, such as for instance participants' motivations, demographic variables (e.g. class or age), or other theoretical concepts and contextual information (Antaki & Widdicombe, 1998; Heritage, 1984, Ten Have, 1999; Potter, 2004).

Second, I focussed on sequences of utterances, rather than isolated utterances. This is necessary because the meaning of utterances and the actions they perform is considered dependent on their sequential context. In addition, participants continuously and inevitably display their understandings of previous turns in their utterances (Heritage, 2001, Antaki & Widdicombe, 1998). Hence, a focus on sequences and understandings displayed in them, is a useful tool for the validation of analytic claims regarding the meaning and function of statements (Hutchby & Wooffitt, 1998; Potter, 2004; Sacks, Schegloff & Jefferson, 1974). It is what Hutchby and Wooffitt (1998, p. 729) call the 'next-turn proof procedure',

Third, I took into account that in principle, *all* details of talk can be meaningful for the production of actions (Hutchby & Wooffitt, 1998), such as laughter, emphasis or pauses (see example 2 in section 3.1).

In addition to these principles, I can identify several 'tools' which I used in the analysis. First of all, in addition to noting patterns, I looked for variability in content and design of statements, between (kinds of) respondents, and within individual interviews. As Potter and Wetherell (1987) argue, the selection of one description rather than another is based on the function which a certain description

can fulfil at a particular point in the conversation. Therefore, variability is a valuable tool to gain insight into the functions of descriptions (Potter, 2004a).

Second, I found it helpful to continuously ask questions of the data (cf. Madill, Widdicombe & Barkham, 2001), such as 'what is this participant doing in this turn?' (Pomerants & Fehr, 1998) 'why this (utterance/phrase/action) now?' (cf. Hutchby & Wooffitt, 1998; Wong & Olsher, 2000) and 'to what interactional, interpersonal problem is this statement a solution?' (cf. Hutchby & Wooffitt, 1998).

A third 'tool' was the DA and CA literature; I made use of findings regarding discursive devices and their functions in previous studies. Particularly useful were devices identified in the management of moral and normative activities, as discussed above. However, considering the *situated* nature of language use and the actions it performs, I always examined how particular discursive devices were used and what they accomplished *in situ*, in particular stretches of talk-in-interaction. This seemed all the more pertinent to my analysis, as I was dealing with talk obtained in a 'foreign', non-western culture, between non-native speakers (see section 2.3).

A fourth 'tool' for analysis were deviant cases. As several authors have pointed out, if one or a couple of cases do not fit in with an analytic claim, the claim needs to be adjusted in such a way that it can include these anomalies as well (Potter, 2004; Potter & Wetherell, 1987; Willig, 2001). On the other hand, if one can show that certain features of the extracts make that they are recognizably different from the 'average' extract, this strengthens the analytic claim (Potter & Wetherell, 1987). This is especially so if one can show that the participants orient to the anomalous nature of the interaction (cf. Potter, 2004).

A fifth tool, used to refine my analysis, was to discuss analysis with colleagues and supervisors, to 'test' the credibility of my claims and modify where necessary.

In a sense, the analysis continued in the writing up of this thesis (cf. Willig, 2001). Selection of extracts occurred hand in hand with the formation of a story line. As ongoing analysis showed increasingly the relevance of normative and moral issues in constructions of infertility, I decided to build the thesis around these issues. This informed further selection of extracts for discussion in the thesis. In addition, I selected extracts for presentation in the thesis because they were clear, 'typical'

examples of a certain utterance design, pattern or action which I had identified in a collection of instances.

The kind of data which I use in my study raises certain methodological issues, which some may consider to affect the validity of my analytic claims. I will address these issues in the next section.

3.4 Methodological issues

CA studies, and to a lesser extent DA studies, normally analyse naturally occurring speech between native speakers, who belong to the same or similar socio-cultural community as the analyst. In this section, I will explain why they tend to focus on this kind of data, and what sorts of methodological issues need to be addressed when relying on the kind of interview-data which I used in my doctoral research. However, a full discussion of these methodological issues will have to wait until I have presented the analysis.

3.4.1 Interview data

This study is based on interview data. Conversation analysts have a 'dispreference' (ten Have, 2002) for this kind of pre-arranged, set up and contrived data (Speer, 2002, ten Have, 2002b). Instead, CA relies on naturally occurring data, to the extent that it is at times even built into definitions of CA (Speer, 2002). Hutchby and Wooffitt (1998, p.14) for instance, describe CA as 'the study of *recorded, naturally occurring talk-in-interaction*' (italics in original). DA is more ecclectic in its use of data, but over the years, discourse analysts, who make use of conversation analysis, have increasingly adopted CA's dispreference for contrived data (Potter, 2002; 2004).

Naturally occurring data are considered preferable for several reasons. First, interview data are considered an inadequate surrogate for actual practices (Atkinson & Heritage, 1994; Potter, 2004). A second, related reason is that the researcher's agenda and analytic ideas would make interview data contaminated and biased (Potter, 2004a; ten Have, 1999, 2002). Hepburn and Potter (2003, p.183) for instance, argue that interview data, 'flood' the research interaction with the researcher's categories and assumptions. Presumably, this is thought to be the case

because the researcher's agenda is built into the interview questions. Therefore, Potter (2004a) argues that naturally occurring talk 'has the enormous virtue of starting with what is there rather than theoretical derived assumptions about what should be there, or the researcher wishes was there'.

Nevertheless, I consider my reliance on interview data justifiable and, moreover, useful. This is so for both pragmatic and more substantive reasons. First of all, as Potter (2004a) acknowledges, at times, use of interview data is necessary as it can be difficult to obtain naturalistic recordings. In my study, various practical problems obstructed recording naturally occurring conversations about infertility. For a start, spontaneous discussions of a sensitive topic like infertility are difficult to capture, as they will be rare. In addition, as mentioned before, recording doctor-patient interactions in infertility consultations was not feasible.

Second, the desire to avoid an undesirable bias due to the presence of the researcher by collecting naturalistic data, appears to reflect a problematic empiricist ideal of 'direct access' (Atkinson & Heritage, 1984, p. 2-3) to phenomena[23]. Note Potter's (2004a, p. 612) claim that naturalistic data enable the analyst to start with 'what is there'. This ideal of unbiased, direct access to 'what is there' seems unattainable, amongst other reasons because of the selective nature of recording and transcriptions[24], as is acknowledged by conversation analysts themselves (Hutchby & Wooffitt, 1998). In addition, as Speer (2002) points out, the desire to obtain 'unbiased' data seems to clash with ethnomethodologists' and conversation analysts' fundamental interests in how social actors actively contribute to the concerted production of meanings. One could argue that 'bias', in the sense that interview

[23] The ideal of direct access to data seems indicative of a tension, noted by several authors, between the empiricist and positivist slant to CA and CA's reflexive ethnomethodological foundation (Atkinson, 1988; Lynch & Bogen, 1994, Pollner, 1992). Appeals to 'what is there' seem certainly problematic for discourse analysts, like Potter, who have adopted and defended a relativistic epistemological stance in many academic publications (Edwards & Potter, 2003; Edwards, Ashmore & Potter, 1995; Potter, 1992; Potter, 1996).

[24] Hutchby and Wooffitt (1998) point out that it is impossible to capture all the details of conversations in transcripts. This would, for a start, make transcriptions impossible to read. Decisions about which features are to be included are made, in part, on the basis of theoretical ideas about what features of talk are relevant for the organisation of conversations (Kendon, 1982; Ochs, 1979). Hence, transcripts are not neutral, theory free representations of conversations (Hutchby & Wooffitt, 1998; Potter, 2004a).

responses are 'influenced' by the presence of other interactants, is not only unavoidable but also a theoretically interesting object of analysis for those interested in social interaction (Speer, 2002). Moreover, the focus on the sequential organisation of talk makes the influence of the interviewer's turns analysable.

Third, Potter (2002) considers use of interview data to be problematic as interviews encourage participants to provide normatively appropriate descriptions. This seems problematic only if respondents attend to normative expectations , and use communicative competencies, specific to the interview situation (cf. Widdicombe & Wooffitt, 1995). However, this seems unlikely (Widdicombe & Wooffitt, 1995), especially in a study like mine, where most, if not all, participants had never been interviewed before.[25] Therefore, as I will show in the analytic chapters, people's orientation to what is normatively appropriate can lead to interesting insights (cf. Coelho, 2005), for example into how normative notions are used by participants to warrant certain practices.

Fourth, the use of interview data seems justified as several scholars, including conversation analysts, have argued that there is no black and white distinction between natural and non-natural or contrived data (Potter, 2002; Speer, 2002, ten Have, 1999a, 2002b). For instance, 'naturally occurring' speech can be seen as contrived in that participants will usually have been asked for their informed consent and will thus be aware that recordings are made (Speer, 2002). On the other hand, it can be argued that interviews are (at times) 'natural' interactions in that the interview setting is not necessarily consequential for accounts provided in interactions (Widdicombe & Wooffitt, 1995; Speer, 2002). One of the central conversation analytic principles is procedural consequentiality (Schegloff, 1991; 1992): contextual features should only be taken into account when it is observable that, and in what way, conversation partners design their talk according to certain contextual features. Thus, as Widdicombe and Wooffitt (1995) propose, interview data should be treated as 'ordinary' informal conversations, *unless* it is observable that and how respondents attend to the situation as 'being in an interview'.

[25] Several observations attest to participants' unfamiliarity with interviews. For instance, some participants started to provide accounts before I had finished the introduction to the interview, suggesting that they were not aware that I had prepared a list of questions. The issues of anonymity was not always understood as, after I had guaranteed anonymity and confidentiality, some participants started the interview with stating their name (i.e. 'My name is …').

Hence, in my study, I adopt Widdicombe and Wooffitt's (1995) approach to interviews (cf. Potter & Mulkay, 1985). They suggest that interviews should be seen as a useful way to elicit people's accounting practices, in which they exhibit their culturally shared, reasoning practices, as people always, inevitably do in talk (cf. Silverman, 1985).

It should be borne in mind that a discourse analytic approach to interview data is very different from the default approach in the social sciences. Normally, respondents' statements are categorised on the basis of broad similarities in their content and seen as representations of sociological (e.g. marital status) or psychological (e.g. locus of control) variables, and in which the interviewer's questions are ignored (Wooffitt & Widdicombe, 2006). To reiterate some points made before; from the perspective of DA, informed by CA, interviews are social interactions (Wooffitt & Widdicombe, 2006). Attention needs to be paid to the interactional basis of statements, that is, to how statements can be 'touched off' by previous turns. Therefore, analysis should be based on detailed examination of the respondent's *and* the interviewer's turns, and if an interview is mediated by interpreters, his or her turns ought to be analysed as well. In addition, statements should be treated as actions: people do things in their utterances. Furthermore, no detail, including silences, false starts, repairs, should be dismissed as irrelevant.

In conclusion, I argue that interviews, treated as social interactions, can become insightful exhibits of local ways of making sense, and provide useful insights into the interactional and inferential business which participants address in their accounts. Nevertheless, I acknowledge that the generalizability of findings from interviews to situations outside the interview context is not a straightforward and self-evident matter. This is so, in part because, to some extent, the interviewer's questions will restrict and steer respondents' constructions. I dealt with this by asking as open questions as possible (but see section 3.2.2), and to a certain degree, by analysing both questions and responses. I will discuss the issue of generalizability in detail in chapter 10.

3.4.2 Cultural context

The respondents and interpreters in my interviews are Malawians, and the interviews were conducted in Malawi. As this is a culturally foreign context for me as analyst and presumably for most of the readers of my work, this raises the issue of whether, and to what extent, my analysis should be informed by additional (ethnographic) information about the cultural context.

It seems generally acknowledged that a certain cultural competence, informed by cultural knowledge is essential for adequate analysis of interactions (Arminen 2000; Bilmes, 1996; Firth, 1996; Hutchby & Wooffitt, 1998; Pomerantz & Fehr, 1997, Schegloff, 1992). Cultural knowledge is said to be needed for instance for recognizing conversation partners' actions (Arminen, 2000; Turner, 1971), and for access to the inferential resources, or ways of making sense, which are available to interactants (Hutchby & Wooffit, 1998).

When conversation partners and analysts belong to a same or similar socio-cultural community, as is normally the case in CA studies, cultural competence can be taken for granted. However, in a study like mine, the question arises how to remedy a likely lack of cultural competence and knowledge on behalf of the analyst.

Conversation analysts normally refrain from using contextual information, derived from sources external to the conversations themselves. This is mainly on the basis of the aforementioned principle of procedural consequentiality: contextual features should only be taken into account if it is observable that, and in what way, conversation partners design their talk according to certain contextual features (Schegloff, 1991, 1992; ten Have, 1999b). This criterion of procedural relevance is meant to deal with the problem that in principle, there is an infinite number of contextual features which could be deemed relevant for the explanation of certain interactions. The criterion of procedural consequentiality prevents analysts from arbitrarily invoking contexts as being relevant for interactions, just because they and the academic community happen to see them as 'logically' related to the conversation interactions taking place (Schegloff, 1992; Arminen, 1996).[26]

[26] Another reason why conversation analysts do not look at the extra conversational context is because they take issue with the most common means of gathering information about this context: ethnographic fieldwork, in which observations and interviews are 'recorded' in fieldnotes (see Hutchby and Wooffitt (1998), and ten Have (1999; 2004))

Therefore, in order to avoid external information which is not in line with conversation partners' concerns, and irrelevant to the production of their interactions, I have adopted the conversation analytic principle of procedural consequentiality (Schegloff, 1991). I thus avoid referring to the cultural context unless this is demonstrably relevant to the participants and the unfolding of the interaction under investigation. However, as the analysis will show, and as I will discuss later, it seems that I am able to refrain from using external information exactly, and perhaps only, because I used interview data, in which the interviewer belonged to a different cultural community than the respondents and interpreters (de Kok, 2004).

My collection of interview data has other methodological implications as well: participants were non-native speakers of English, or did not speak English. I will address issues of language in the next section.

3.4.3 Language issues: Non-native speakers, interpreters and translations

My study raises various language issues. First of all, all participants, including myself as interviewer and analyst, are non-native speakers of English.
Second, roughly one third of the interviews was mediated by an interpreter. Third, some of the interpreter-mediated interviews were translated into English.

Conversation analysts and discourse analysts have largely worked with materials from native speakers (Wong & Olsher, 2000). The question is whether, and in what way, the fact that participants are non-native speakers matters for the analysis. In an interview with Wong and Olsher (2000) about non-native speaker talk, Schegloff warns against assuming that certain conversation analytic principles will not apply, or apply differently when dealing with speech between non-native speakers, although he acknowledges that for instance pauses and grammatical forms may have different meanings and functions in this kind of interaction. Thus, Schegloff suggests that the criterion of procedural consequentiality should be applied again: if an analyst claims that some features of an interaction arise from the fact that participants are non-native speakers, he or she has to show that and how exactly participants' non-native status is relevant, and oriented to as such by participants.

In my analysis, I partially follow Schegloff's (in Wong & Olsher, 2000) recommendations. Thus, I have analysed my data largely as I would have analysed data between native speakers. However, I would argue that abiding by the principle of procedural consequentiality in itself is not a sufficiently adequate way to deal with the potential influence of limited fluency on people's speech. Thus, I have been more careful than I would normally be in making analytic claims, especially when using certain design features like grammatical forms, pauses, and word choice and when respondents' fluency was obviously limited.

Nevertheless, although at times analytic claims will have to be more tentative, as Schegloff (in Wong & Olsher, 2000) argues, and as I will show in the analytic chapters, analysing non-native speakers' talk is by no means impossible. Analytic claims are never based on one feature of an utterance, but always on a combination of content, sequential placement and various design features. In addition, I base my analytic claims on collections of instances within and across interviews, rather than single cases. These are forms of corroboration which diminish the problem of making claims on the basis of non-native speakers' utterances.

Interpretation and translation raise very similar methodological issues. In the process of translation, it is inevitable that choices have to be made between words and meanings (Riessman, 2000b; Venuti, 1998). This is in part because it is often, if not always, impossible for translators to select a word which has exactly the same meaning as the word which is being translated (Birbili, 2000). Thus, Temple (1997, p. 144) points out that the use of interpreters and translators is 'not merely a technical matter', but 'of epistemological consequence as it influences what is 'found'. Others have emphasized as well that translation and interpretation, are active processes of re-construction rather than a neutral 'passing on' of the message (Wadensjö, 1994; Riessman, 2000b; Temple et al., 2004; Temple, 1997; Pitchforth & van Teijlingen, 2005; Venuti, 1998). Another reason why this is the case is the potential influence of the interpreter on the respondents and the communicative process (Philips, 1960).

Issues of interpretation have been widely discussed, commonly in terms of the validity and correctness of translations (Wadensjö, 1998). Strategies have been proposed to assess the accuracy and validity of translations, like the back-translation of interpretations into the original 'foreign' language. In my study, I pay detailed

attention to interpreter's statements and I obtained translations of their interactions with the respondents in the local language. However, this is not based on a desire to verify whether what they say is correct. Rather, I treat interpreters as active contributors to the concerted accomplishment of meanings and actions (cf. Wadensjö, 1998), and therefore interactions in which they are involved are integral part of the analysis. I will illustrate this approach throughout the chapters, and will discuss further the issues of interpretation and translation in the discussion chapter.

In conclusion, language related methodological issues mean that my analytic claims have to be somewhat more tentative, as my analysis is, more than normally, not based on the 'thing-in-itself'. Nevertheless, I would argue that translated, interpreter-mediated interviews can still form a fruitful basis for the analysis of constructions, the devices thereby used and the interpersonal and interactional business thereby served. However, the usability of interviews, mediated by interpreters and translated afterwards, seems largely an empirical question, which requires a demonstration of analysis of such interviews. In the next 6 chapters I will present and discuss such analysis.

3.5 Conclusion

In this chapter, I have made a case for the use of discourse analysis, informed by conversation analysis, for the examination of constructions of infertility in Malawi, in relation to the management of interpersonal, normative and moral issues. DA, informed by CA enables close examination of constructions in talk, and the actions which they perform as concerted accomplishments. It has proven to be a useful tool to examine the interactional management of morality and normativity and the discursive devices thereby used. I have argued that the use of interpreter-mediated and translated interviews complicates, but does not invalidate the analytic process. I will demonstrate this in the following analytic chapters. To begin with, I discuss in chapter 4 how men and women with a fertility problem construct bearing children as cultural, normative requirement and the functions which this construction performs. In chapter 5, I present analysis of how they talk about causes of infertility, and the interactional and interpersonal issues this appears to raise. In chapter 6, I discuss how respondents describe the actions taken to solve a fertility problem, and how they

account for not taking action (anymore). Chapter 7 pertains to constructions of relationships in relation to the management of (moral) issues of blame. In chapter 8 and 9, I focus on indigenous and biomedical practitioners' constructions: of causes, and of success, failures and problems in helping infertility patients. I will show how these constructions are intertwined with identity work.

Chapter 4. Constructing childbearing as cultural, normative requirement

As mentioned in the literature review (chapter 2), studies of infertility in the developing world stress the many negative social and psychological consequences which infertility has, in particular for women. They are usually related to socio-cultural norms, which mandate that people bear children and which are said to be especially strong in non-western societies (Inhorn, 2003; Riessman, 2002), and African societies in particular (Dyer et al., 2002). For instance, Dyer et al. (2004, p. 964) attribute social consequences to cultural, pronatalist norms when they state that 'in a few cases, the reactions of other family members to infertility seemed to be based on perceived violations of social norms.'[27] Gerrits (1997, p.47) appears to attribute social exclusion to 'culture', and therefore arguably to cultural norms, when she states about the infertile women in her study 'the culture was also hard on them: they are excluded from important social events and ceremonies'.

However, attributing the negative consequences of infertility, such as social exclusion, stigmatisation, and various forms of marriage breakdown, to socio-cultural norms appears problematic. This first of all, because this implies that people's behaviour, such as ostracising people with a fertility problem or engaging in extramarital affairs, is seen as governed by cultural rules or plans. Several scholars have pointed out that the idea of rule-governed behaviour is problematic (Garfinkel, 1967; Heritage, 1984; Shotter, 1980; Suchman, 1987; Wittgenstein, 1953). Prescriptive rules seem unable to deal with contingent and unpredictable circumstances of action which are bound to emerge, as the rules would have to specify in advance under which circumstances they should be followed (Heritage, 1984; Suchman, 1987; Wittgenstein, 1953). In addition, treating social action as governed by cultural norms, fails to acknowledge people's knowledgeability and human agency in the creation of social actions (Garfinkel, 1967; Heritage, 1984;

[27] However, in another paper, Dyer et al. (2002) argue that 'African culture' cannot account for the many negative social consequences of infertility, as these are observed in developing countries in other parts of the world as well. They suggest that instead, the implications of infertility are secondary to the low economic and social status of women in the developing world.

Hutchby & Wooffitt, 1998). Garfinkel's (1967) famous criticism is that it makes people into 'cultural dopes' (Garfinkel, 1967), or puppets of social norms (Garfinkel & Sacks, 1970), who behave in accordance with ready-made options provided by their culture.

Second, the basis for authors' claims regarding the existence of pronatalist norms is often unclear, or rests on problematic circular reasoning. Some authors appear to infer a socio-cultural norm which prescribes childbearing from informants' statements about social consequences of infertility and experienced social pressure to give birth. They then use this norm to explain the same consequences.

In this chapter, I adopt an alternative approach to 'norms of procreation', which acknowledges that treating such cultural norms as explanation for behaviour is problematic. As is typical for approaches drawing upon ethnomethodology, I make people's orientation to the normative nature of procreation into a topic of enquiry, rather than using it as a resource for analysis to explain phenomena such as the negative social consequences of infertility.

The analysis presented in this chapter is developed from initial analyses of two data sets; one set of extracts in which respondents answer questions about why people want to bear (more) children, and another set of extracts in which respondents talk about consequences of not bearing (more) children. Initial analysis made apparent that in both data sets, respondents refer to the cultural context in their explanations and attend to certain culturally shared, normative expectations. The analysis presented in this chapter will focus on how men and women with a fertility problem, significant others, biomedical practitioners and indigenous healers and actively construct cultural 'norms' regarding childbearing in situ, that is in particular interactions. As I will show, this leads to novel insights into the interactional, rhetorical functions which constructions of childbearing can fulfil.

4.1 Constructing bearing children as normative requirement

Respondents can be seen to attend to bearing children as something which people are expected, and ought, to do. Consider extracts 1 and 2, both from interviews with people with a fertility problem.

Extract 4: 1 Int. 47 inf.w / inf.m[28] ((two people, husband and wife are interviewed. The husband has just explained that, and why, he would like to have children.))

347. I And for you, is it would you want to have children for similar reasons?
348. Rw Yes, or maybe I could say: three to four.
349. I Uhu hhuhuhu
350. Rw To have the children in the family it is eh (blissful)
351. I uhu
352. Rw (blessing), from God.
353. I Uhu
354. Rw It means that family has now changed.
355. Rh Transformed it.
356. Rw Transformed.
357. I uhu
358. Rw As of now we are I can I cannot say that we are grown up,
359. I uhu
360. Rw we are still young because we don't have a child, but if we can have a child, it
361. means we have grown up now.
362. I Uhu, that's when you really feel that you're an adult, or?
363. Rw Yes, yes. Because we know that now, we are going to to support another, we are
364. the parents,
365. I Uhu
366. Rh but now we are not the parents.
367. Rw We are still kids.
368. Rh We are still [kids
369. I [uhu
370. Rh Hhuhu
371. I Okay, yah

Extract 4:2 Int. 53 inf.w ((respondent has 2 children, but has indicated that she would like to have six or seven children))

429. I Aha. Okay.(1) A:nd, (.5)
430. ehm I was wondering, can
431. you tell me something
432. more about what is
433. better about a big family
434. of six or seven children
435. rather than a family of
436. two children?

437. T	*Hhehehe, she says, because*[29]	Hhehehe, akuti, poti
438.	*these friends of ours have two*	anzathuwa amakhala ndi
439.	*or three children, but she says,*	ana awiri kapena atatu,
440.	*now for you, the happiness (.)*	koma kuti tsono, inuyo,
441.	*she doesn't (.) she really*	chimwemwe (.) saakufuna
442.	*wants to understand your*	(.) kumvetsetsa,chimwemwe
443.	*happiness (.) where is it*	chanu, (.) chili pati penipe-
444.	*exactly, that you would be*	ni, kuti mudakakondwera
445.	*happy with seven or six, and*	seveni kapena sikisi, osati
446.	*not just two?*	awiri basi?

((several lines omitted in which the respondent mentions that having children would stop her menstruation and that children would help them in their home))

[28] For a list of codes used to indicate the different types of respondents, see Appendix D
[29] Italics denote that text is a translation of the interactions between respondents and interpreters.

467. R		*Is it not because I admire my*	Nanga sindimatsilira
468.		*friends who have given birth*	anzanga abereka-bereka ana
469.		*to five, four children,*	faifi, folo,
470.T	And she desires very		
471.	much when [she sees her	[*Me, I have given birth to two*	[Ine ndidango bereka awiri
472.	old age mate,		
473.I	Uhu		
474.T	They have always a baby		
475.	on the back,		
476.I	Oh[o		
477.T	[and she here like an		
478.	old woman, she is		
479.	moving alone,		
480.I	Okay:		
481.T	without any baby.		
482.I	I see:=		
483.T	=Psychologically she is		
484.	affected with that.		

Both respondents are asked about why they would want to have (more) children. In the first part of their response, the respondents attend to bearing (more) children as desirable. In extract 1, the wife describes having three to four children as 'blissful' (line 350) and as a '(blessing) from God' (line 352). In so doing, she portrays bearing children as something positive and thus desirable. In extract 2, the respondent attends to bearing children as desirable by making clear that she admires her friends, 'who have given birth to five, four children' (lines 467-469). Hence, the respondent construct bearing four or five children as admirable, and by implication, desirable. She provides a basis for her admiration and desire by pointing at a contrast between her and her friends 'Me, I have given birth to two' (line 471). Note that the respondent starts her claim of admiration with a rhetorical question: 'is it not' (line 467). Rhetorical questions are not asked in order to obtain an answer, but to make a point (cf. Billig, 1987). The interpreter indeed treats the question as rhetorical by not responding to it, nor including it in her translation (lines 470-484). 'Is it not' emphasises the respondent's admiration for her friends who bear four or five children, unlike herself.

In the second part of their response, the respondents (extract 1) and interpreter (extract 2) account for the desire to have (more) children. In their accounts, they draw upon various 'membership categories' (Sacks, 1974; 1992): culturally available categories which are used to classify people, such as 'mother', or 'doctor'. In extract 1, the respondents characterise themselves as 'we are still young'

(line 360) and ‘we are still kids’ (line 365 and 366). In extract 2, the interpreter describes the respondent as ‘like an old woman’ (line 478). The respondents and interpreter make clear that their typification is based on the absence of children. In extract 1, the wife states ‘we are still young because we don’t have a child’ (line 360). In extract 2, the interpreter implies that her categorisation of the respondent as ‘like an old woman’ is based on the observation that ‘she is moving alone, without any baby’ (line 478-481).

The categories used to describe the respondents are contrasted with other categories of people who do bear children. In extract 1, the categories of ‘still young’ and ‘still kids’ are contrasted with the category ‘grown up’: ‘I can cannot say that we are grown up’ (line 358). The wife constructs the category ‘grown ups’ as dependent on having children by saying ‘but if we can have a child, it means we have grown up now.’ (line 360). The respondent uses an ‘if-then’ construction which, in this case, makes having a child into a logical, necessary and sufficient condition for belonging to the category ‘grown ups’ (cf. Potter & Edwards, 1992). In extract 2, the membership category ‘old woman’ who is ‘moving alone’ (line 478), ‘without any baby’ (lines 480) forms a contrast with the category ‘old age mate’ (line 472), who ‘have always a baby on the back’ (line 473-474). ‘Always’ functions here as a scripting device (Edwards, 1994; 1995) which makes bearing children into a recurrent, predictable feature of ‘old age mate’. Note that it is reasonable to infer that ‘old age mate’ refer to the respondent’s peers, or ‘old pals’ of the same age, rather than to old people. This is so in part because this description is the translation of ‘my friends’ (line 467-468), who can, according to common sense, be expected to be of an age, similar to the respondent’s. In addition, ‘old age mate’ (line 472) is hearable as referring to people who are (relatively) young due to the contrast invoked between an old woman moving along and the old age mates.

In more technical terms, in extracts 1 and 2 bearing children is made relevant as a ‘category attribute’ (Sacks, 1992) of certain categories of people. Category attributes are features, which are conventionally associated with certain membership categories (Sacks, 1992; Watson & Weinberg, 1992). Sacks (1974, 1992) and others (Antaki & Widdicombe, 1998; Turner, 1974; Watson & Weinberg, 1992) have shown that people have culturally shared, common sense knowledge and

expectations regarding various attributes of categories of people, including their knowledge, rights or typical, category bound activities (CBA). For instance, an expected activity of mothers is that they pick up their baby when it cries (cf. Sacks, 1992). In extracts 1 and 2, bearing children is made relevant as a category attribute of grown ups (extract 1) and (relatively) young people (extract 2), and *not* bearing children or having 'a baby on the back' as category attribute of those who are still young, in the sense of still kids (extract 1), and old women (extract 2).

There is a normative dimension to category attributes. As Hester (1998) points out, they are *proper* features of members of the relevant category, and not exhibiting a certain category attribute can have certain consequences. For instance, a child's failure to display attributes deemed proper for their stage of development can form the basis for labelling the child as 'deviant', or 'having a problem' (*op cit.*). Watson (1978, p. 106) too, draws attention to the consequences of absence of category attributes: if a member of a certain category does not display a relevant category attribute, this becomes 'noticeably absent' and 'specially accountable'. Thus, category predicates are of a normative nature in that members from a certain category usually display the relevant category predicates and *ought* to do so; otherwise some sort of interactional or interpersonal trouble is to be expected. Mothers *ought* to pick up their crying baby. If they do not, it is likely that they will be held accountable and this may have implications for their status as a 'proper' mother.

The respondents and interpreter attend to the normative nature of the CBA 'bearing children', by making clear that not bearing children has certain consequences. First, they point out that not bearing children leads to the allocation to alternative categories of 'still young', 'still kids' and 'old woman' instead of to 'grown ups' and 'age mates'. These alternative categories are recognizably inappropriate, in part because they represent stages of life, which can be arranged in sequences of higher and lower positions (cf. Hester, 1998; cf. Sacks, 1974). For example, one possible sequence is 'baby', 'toddler', 'adolescent', 'adult', 'elderly person'. The stages of life to which the respondents are allocated are recognizably too 'low' or too 'high' for them, considering the respondents' appearance, and

because they make clear that they are trying to achieve a pregnancy, which is highly unusual for kids and old women. Second, in extract 2, the interpreter states 'psychologically she is affected with that' (line 493). Thereby she makes clear that not bearing children has significant negative implications, and thus confirms the status of bearing children as a requirement.

Thus, in extracts 1 and 2 the respondents can be seen to draw upon culturally shared, normative expectations regarding membership categories and their attributes: they attend to the notion that certain categories normally bear children, and ought to do so. Respondents also construct bearing children explicitly as a cultural normative expectation and requirement. Consider extracts 3 to 5.

Extract 4:3 Int.36 HSAs/S.O ((a female and male (Rm) HAS were interviewed at the same time. Only the male respondent speaks in this extract)).

95. I Okay yah. And what would you say? Is it important to have children?
96. Rm Eh, you know it's in Malawi, culturally
97. I Uhu
98. R Eeh if you marry, (let's/they) say I married eh a woman.
99. I Uhu
100. Rm E:h the main emphasis of of parents they say you have to have children.
101. And if at all you don't have children, they have (.) questions, Why? (1.5) Why?
102. I And w- why what?
103. Rm Why have no children?
104. I Uhu
105. Rm Eeh that's the question that those parents raise if at all married, you actually stay for
106. several years having (no) children.
107. I Uhu, yah.
108. Rm So it's culturally, culturally.

Extract 4:4 Int. 44 inf.w

146. I Ehm, can you explain to me, you said when you got married you really wanted to
147. have children, from the start of (your/the) marriage. Why did you want to have
148. children?
149. R (.) Hhu[hu.
150. I [[Hhuhu
151. R It's nature! This is my, our, this is our culture.
152. I Uhu
153. R Yes, if you (are/feel) married, you must have the children.
154. I uhu
155. R If you don't have (.) so my parents, our parents say that ah, she's barren she's
156. barren,
157. I uhu
158. R go away, go away.
159. I Hm::
160. R Hm:
161. I Go away?
162. R >Yeah< go away. She's barren. Marry another woman.

Extract 4:5 Int. 58 c.o.

529. I Hm. Okay. A:nd ehm w- what do you think the: the- the solutions what
530. kind of solutions will women seek if they see that their marriage, their
531. marriage remains childless. What what will they tend to do first about
532. it for example °or, do you have any idea about that?°
((some lines omitted in which respondent states to have no idea))
535. R But I have already stated that they have inferiority in the
536. community, they become depressed.
537. I hmhm
538. R They are not happy. Because they, the community they recognise that
539. if someone has been married he has to have a child and with our
540. culture we say even in the (both parties) the parents (of/what) the husband
541. and the parents of the woman they need to have to see a child.

In extract 3, the interviewer asks the respondent whether it is important to have children (line 95), in extract 4 she asks why the respondent herself wanted to have children (line 147-148). In extract 5, the interviewer asks about the solutions which people seek when no children are born, but the respondent answers in terms of consequences which people who do not bear children experience (line 529-532).

A first observation which I would like to make is that there are several references to the local, cultural context in the three extracts, mostly occurring at the start of the responses. In extract 3, the respondent states in line 96 'in Malawi, culturally'. He repeats, and thereby stresses, at the end of the extract that 'it's culturally, culturally.' (line 106). In extract 4, the respondent refers to 'our culture' (line 151). In extract 5, the respondent refers to 'the community' (line 536; 538), and 'with our culture' (line 539-540).

Second, respondents make bearing children into an imperative. They do this to begin with by using verbs like 'have to', 'must' and 'need to'. In extract 3, the respondent describes parents as saying 'you have to have children' (line 100). In extract 4, the respondent states 'you must have the children' (line 153). In extract 5, the respondent states that the community recognises that 'he has to have a child' (line 539). Note that by saying that the community *recognises* the need for a child (line 539), the respondent attends to this need as an objective fact, rather than for instance an opinion. In addition, the respondents make clear that bearing children is required by pointing out that not doing so has certain consequences. In extract 3, the respondent says that if you do not have children, parents 'have (.) questions. Why? (1.5) Why?' (line 101) and 'why have no children?' (line 103). In extract 4, the

respondent explains that her parents were saying 'she's barren she's barren', and told her to 'go away, go away' (line 158), and told her husband to 'marry another woman' (line 162). In extract 5, the respondent points out that people who do not bear children suffer from 'inferiority in the community' (line 522) and 'become depressed' (line 523).

Third, respondents construct the imperative of bearing children as generally valid. They do this by their aforementioned references to the cultural context, which precede references to the need to bear children. Consequently, the requirement of bearing children is located within the particular cultural setting. Therefore, the need for children can be inferred to be widespread, pertaining to any 'proper' member of the cultural group. Interestingly, the respondent in extract 3 constructs bearing children as both cultural *and* natural. In line 151, at the start of her response to the question why she wanted to have children, the respondent exclaims 'it's nature!' (line 151). However, this can be seen as sustaining her construction of bearing children as generally valid norm. For, constructing bearing children as 'nature', implies that it is what 'naturally', and thus normally happens. In addition, it suggests that it is what *should* happen, as doing what is *not* natural is normally seen as undesirable.

In addition, the respondents make the requirement of bearing children into a general norm by means of if-then constructions (Potter & Edwards, 1992), in which 'then' is implied. In extract 3, the respondent states ''if you marry' (line 98), followed in line 100 by '[then] you have to have the children' (line 100). In extract 4, the respondent says 'If you (are/feel) married, [then] you must have the children' (line 153). In extract 5, the respondent says in line 539: 'if someone has been married, [then] he has to have a child'. These if-then constructions make bearing children into a law-like corollary of marriage. In other words, respondents make relevant a 'law', or 'norm', framed as a *cultural* norm by the references to the cultural context, which prescribes that married people bear children. In extracts 3 and 4, the respondents use if-then constructions in their descriptions of the consequences of not bearing children as well. In extract 3, the respondent states '*if* at all you don't have children (…) they have (.) questions' (lines 100-101), in extract 4, '*if* you don't

have (…) [then] ah my parents say (…) go away, go away' (lines 155-158). By constructing a law-like connection between not having children and the occurrence of certain consequences, respondents confirm the general validity of the norm that 'one' should bear children.

Furthermore, the respondents construct the requirement to bear children as a generally valid 'law' or 'norm', by using general pronouns like 'you' (ex. 3 line 98, 100, 105) and 'someone' (ex. 5 line 526), and other general references like 'parents' (ex. 1, line 100), 'the parents' (ex. 4, line 527, 528), 'the husband' (ex. 5 line 527), and 'the woman' (ex. 5, line 527). By means of these generic referents, the respondents establish the need for children as something which is generally valid, rather than, for example, an individual characteristic of the particular men involved.

Thus, I have shown how respondents construct bearing children as normative expectation and requirement. In so doing, respondents attend, implicitly or explicitly, to cultural, common sense expectations that certain kinds of people bear children. In the next section, I will focus on how explicitly invoking the cultural context and attending to bearing children as cultural requirement can fulfil certain interpersonal and interactional tasks.

4.2 Justifying practices by invoking cultural needs and expectations

In extract 4, the respondent identifies marriage breakdown as a consequence of fertility problems. As said (chapter 2), practices such as divorce, polygamy and extramarital relationships are mentioned in the literature as a consequence of infertility as well. In this section, I will examine how respondents construct, and account for, such practices, and how they thereby draw upon the notion of bearing children as something which is culturally expected and required.

Extract 4:6 Int.48 s.o.

54. R And if African doctors <u>fail</u> then it is up to the man, if he feels it is not his fault –
55. I Uhu
56. R then you look for an alternative.
57. I Like, (1)what kind of alternative might he look for?
58. R (.) You need children. In our context, in our eh cultural beliefs, if you marry have no
59. children then you are unfortunate, very unfortunate.

((respondent mentions several problems of not having children))

67. R So, if I've a alternative, what alternative can you have, if you love your wife you cannot
68. divorce,

69. I Uhu
70. R automatically you will marry another wife.
71. I Uhu
72. R So you automatically become a polygamist.

Extract 4:7 Int. 10 c.o. ((respondent has mentioned just before that 'before a year' a man has already gone somewhere to test his fertility, and stated that 'people prefer a man in the family (if) fertility can be proved.))

541. R Normally in a tradition, they give you maybe up to e:h three months.
542. I (1) Hmhm:
543. R Suppose [eh people
544. I [Three months!
545. R People are married today
546. I Hmhm haha
547. R They expect by three months ((smiley voice)) the woman hehehe he [she]
548. has to be impregnated.
549. I Yah, yah
550. R Yeah.
551. I Hmhm
552. R ↑Well, ↑this couple stays for three months, nothing happens.
553. I Hmhm
554. R Then it goes maybe to what age, ↓nothing happens. ·h Now. (.5) When
555. it comes to three years. This time, a man must go to another woman.

Extract 4:8 Int. 50 ind.h/inf.m ((R has mentioned at the start of the interview that he used to have a fertility problem himself, because fo which he married a 2nd wife))

1640. I Okay. So do you think it's
1641. a good solution that if a
1642. man thinks that a lady is
1643. having a problem that he
1644. goes and finds another
1645. wife?

1646.	T	*She says do you think about*	Atimukuchighanaghanira
1647.		*it as=*	kuti=
1648.	R	*=Yes!*	=Eeh!
1649.	T	*a good thing if it is the man*	Nchiwemi para mwanalu-
1650.		*that goes out to find that er,*	me ndiyo akufumanga ku-
1651.		*then a woma- (.) I get*	walo kukapenjanga kuti ah,
1652.		*another woman to bear me*	ipo, mwanak (.).nitore mwa
1653.		*a child even if you have*	nakazi munyakhe anibabire
1654.		*another woman if the*	mwana, napara uli namwa-
1655.		*woman is the one that*	nakazi munyakhe para
1656.		*finds out that the man has*	mwanakazi ndiyo wasanga
1657.		*(.) is (.) has no strength?*	kuti mwanalumi alina (.)
1658.			aliuje (.)alije mphamvu?
1659.			
1660.	R	*In our thoughts, according*	Mumaghanaghaniro gha
1661.		*to our way of living,*	ise, pachiwunthu chithu, ka
1662.		*because a child is needed*	mwana wakukhumbika,
1663.		*isn't it?*	eti?
1664.	T	*Hm.*	Hm
1665.	R	*It's good. Raising the*	Nchiwemi. Kukwezga zina
1666.		*father's name. Problem*	lawiske. Suzgo pal- Eeh.
1667.		*noth- Yes.*	

1668. T He says is it
1668. the child, I can say
1669. what, is it the child
1670. who makes the
1671. father's name to be
1672. great.
1673. I Uhu
1674. T who ( ) the father's
1675. name. A father can get fame
1676. just because of the son.
1677. I Uhu
1678. T So, to a man according
1679. to our tradition it's quite
1680. normal for a man to go
1681. searching for another
1682. lady if that lady inside
1683. the house isn't fertile.

Extract 4:9 Int.16 m.d. (expat.)

858. I Yah, okay hmhm. Yah and ehm about the other solution you mentioned that
859. they may go to another man or to another (.) woman what do you think about
860. that as a solution
861. R Eh well it's not- I mean if you really want to get pregnant you have to have
862. unprotected sex. So in this country it's really not, it's not very smart to have
863. sex with somebody else just to get pregnant.
864. I Hmhm
865. R But on the other hand if they can't get pregnant because their husband is HIV
866. positive.
867. I hmhm
868. R Ehm.(2) So: yah, t-, I can't blame them. Because it is important here.
869. I Hmhm
870. R And ehm if they don't get, even if it's caused by the husband, if the woman
871. can't get pregnant, it's a high chance that the man is going to run away from
872. the woman
873. I Hmhm
874. R but sometimes if the woman already has children another partner, if she can't
875. get children from this partner, many times they just want more children. It's
876. also possible that the woman is just going to run away.
877. I Uhu
878. R So. I can't blame them but I don't think it's good.
879. I You understand that they will seek that solution but that's again it's ( )
880. R Yah, no in this culture, in hm- it's very logic that they will, that they will do it
881. that way but it's just risky behaviour

In extracts 6 and 8, the respondents talk about polygamy. In extract 6, the respondent states 'you will marry another wife' (line 70) and 'become a polygamist' (line 72). In extract 8, the interviewer asks whether the respondent thinks that it is 'a good solution' (line 1641) that a man 'goes and find another wife' (line 1644-1645). The interpreter translates this as whether he thinks it is 'a good thing' if a man gets 'another woman to bear me a child' (line 1649-1653). In extracts 7 and 9, the

respondents address the issue of extramarital affairs. The respondent in extract 7 has mentioned just before that 'before a year a man has already gone somewhere', 'to test his fertility to to a certain woman'. In the extract itself, he refers to a situation in which 'a man must go to another woman' (line 555). In extract 9, the respondent is asked, and provides an opinion, about the situation that people 'go to another man or to another (.) woman' (lines 858-859).

In all four of these extracts, the respondents account for the practices of polygamy and extramarital affairs. In their accounts, they all attend to bearing children as a cultural expectation or need. In extract 7, the respondent constructs bearing children when married as expected when he states 'they give you maybe up to e:h three months' (line 556), and explains that when 'people are married today' (line 545), 'they expect by three months ((smiley voice)) the woman hhehehe he has to be impregnated.' (line 562-563). In extracts 6, 8, and 9, the respondents make relevant a need for children. They do so first, by means of the explicit references. In extract 6, the respondent states 'you need children' (line 58). In extract 8, the respondent says 'because a child is needed isn't it' (line 1662-1663). Second, in extract 9 the respondent attends to a need for children by stating that 'it's important' (line 868) to have children. Third, in extracts 6 and 9, the respondents attend to a need for children by pointing out that not bearing children has negative consequences. In extract 6, the respondent states 'if you marry have no children, then you are unfortunate, very unfortunate' (line 53). By the repetition of 'you are unfortunate' (line 59) and the word 'very' (line 59), the respondent emphasises that not having children is a problem. In extract 9, the respondent addresses negative consequences of being childless as well. He explains that 'it's a high chance that the man is going to run away' (line 871) and that also the woman may leave (line 876). By pointing out that not bearing children is problematic, the respondents make clear that there is a need to bear children. Fourth, in extract 8, the respondent points out the benefits of having a child, for instance having children helps 'raising the father's name' (line 1665-1666). The interpreter makes clear that having a child is beneficial as well: 'is it the child who makes the father's name to be great' (lines 1669-1672) and 'a father can get fame just because of the son' (line 1675-1676).

The respondents construct the expectation of, or need for, children as a cultural expectation or need, because references to the cultural context co-occur with references to the necessity of children. In extract 6, the respondent states 'in our context' and 'in our cultural beliefs' (line 58), immediately after he has claimed 'you need children'. In extract 7, the expectation of pregnancy within three months is preceded by the statement 'Normally in a: tradition' (line 556). In extract 8, the respondent starts his response with implicit references to the cultural context: 'in our thoughts' (line 1660) and 'according to our way of living' (line 1661). The interpreter subsequently refers to the cultural setting when he states 'according to our tradition' (line 1678-1679). Note also that by means of the tag question 'isn't it?' (line 1663), the respondent invites a confirmation from the interpreter. He can therefore be seen to orient to the idea that 'a child is needed' as shared, culturally available knowledge (cf. Edwards, 1997). In extract 9, the importance and need becomes cultural by the references to 'here' (line 868) and 'this culture' (line 880).

The construction of a cultural expectation or need for bearing children forms a justification for polygamy and extramarital affairs. It does this first of all by providing a rationale. A cultural, normative requirement to bear children makes understandable that members of the relevant cultural setting will attempt to solve this problem, for instance by engaging in polygamy or extramarital affairs. Hence, the construction of bearing children as cultural need justifies practices like polygamy and extramarital affairs by making them into reasonable, practical solutions to the problem of failing to meet a requirement. This claim is supported by respondents' orientations. In extract 10, the respondent attends to the idea that the cultural importance of children forms a justificatory rationale when he states: 'in this culture, in hm- it's very logic that they will, that they will do it' (line 880). In extracts 6 and 9, polygamy and going to another man or woman are attended to as solutions for infertility. In extract 6, this is the case when the respondent puts forward polygamy as an 'alternative' (line 56) to 'African doctors' (line 54), and thus allocates the practice of polygamy to the same category as a practice like seeking help from indigenous healers. In extract 9, the interviewer talks about going to another man or woman in terms of 'the other solution you mentioned' (line 858). She thereby refers

to, and confirms, the respondent's previous classification of extramarital affairs as solution for fertility problems.

By framing the practices of polygamy and extramarital affairs as practical solutions, respondents take away their potential dubious, immoral connotations. Note that the respondent in extract 6 achieves this effect as well by making clear that not divorcing one's wife is based on love for her: 'if you love your wife you cannot divorce' (line 67-68). Hence, the respondent imbues not divorcing, and its implication, starting a polygamous marriage, with a righteous motivation: love for one's wife. Thereby he takes away its blameworthy, immoral character.

Second, respondents' orientation to a cultural expectation of, or need for, bearing children justifies practices of polygamy and extramarital affairs by playing down people's agency, and thereby, their responsibility. McHoul (2004, p.438) has noted how references to culture can be used to displace personal responsibility; 'imbrication in 'a culture' can become a defence in its own right', by making someone into a 'mere member of a larger constituency of wrong-doers'. The respondents in extracts 6 and 7 appear to attend to the notion that the cultural requirement of bearing children mitigates their agency and responsibility. In extract 6, the respondent states that 'automatically' (line 70) you will marry another wife and 'automatically' (lines 72) you become a polygamist, thus suggesting that the practice of polygamy is independent from men's volition or agency. In extract 7, the respondent does this when he states that 'a man must go to another woman' (line 555).

Extract 10, displayed below, is a particularly clear case in which the reference to the cultural context serves the function of justifying a practice by mitigating actors' agency. In this extract, the respondent comments on the practice that if a man is infertile, his brother has sex with his wife.

Extract 4:10 Int.35 s.o.

120. I I see. And you say eh previous- previously it used to be common that then the brother
121. would for example sleep with the wife.
122. R Yes, it's the culture.
123. I Uhu
124. R In some places, I understand, they might still be doing it.
125. I Uhu
126. R Let's say (.) a husband is out for the country for a period so they are afraid that the wife

127. may misbehave.
128. I Uhu
129. R So they ask the young brother. But these days because of this deadly disease,
130. I uhu
131. R AIDS, they are avoiding it now.
132. I Okay, I see. And you say they are afraid that the wife may misbehave? In in what sense?
133. R Promiscuity. They end up having external affairs.
134. I Okay, I see. So then people would think like it's better to arrange it ourselves
135. R Yes
136. I than that she, chooses someone else or,
137. R Yes.
138. I Okay, I see.
139. R So it's the culture, there's nothing wrong with that.
140. I Yah.

The respondent, asked about the practice of someone sleeping with his brother's wife, provides initially 'culture' as a self-sufficient explanation: 'yes, it's the culture' (line 122). He repeats this claim as upshot of his explanatory account (lines 124 - 133): 'So it's the culture' (line 139). Consequently, responsibility for sleeping with one's brothers' wife is diverted away from the man to 'the culture'.

A fourth way in which the construction of a cultural expectation, or need, to bear children fulfils its justificatory function, is by making relevant the routine and recurrent nature of practices like polygamy and extramarital affairs. Because respondents make clear that these practices are based on a cultural notion that children are necessary, the practices themselves are constructed as cultural as well. By implication, they are portrayed as shared by members of the cultural tradition, and therefore as widespread, recurrent, and routine.

Edwards (1994; 1995) has called descriptions, which establish events or actions as routine, recurrent and predictable, 'script formulations'. Several other script formulations can be observed in the extracts. For instance, respondents use plural and generic pronouns and indeterminate nouns. In extract 6, the respondent refers to the generic 'you' who needs children (line 58), cannot divorce and automatically becomes a polygamist (line 70). In extract 7, the respondent talks about 'people' in general (line 543 and 545), 'a man' and 'woman' (line 555), in extract 9, there are references to 'the husband' (line 870) and 'the woman' (line 870, 874, 876). By means of these generic descriptors, respondents construct the need for children, and practices which people engage in to meet this need, widespread and routine.

Another scripting device can be observed in extracts 7 and 9, in which the respondents introduce a hypothetical case: 'suppose people are married' (extract 7 line 543) and 'let's say (.) a husband is out of the country'' (extract 9 line 125). Widdicombe and Wooffitt (1995) point out that hypothetical cases can bring together recurrent features of a phenomenon in one (hypothetical) instance. Thus, by describing a man having an affair with another woman and someone sleeping with his brothers' wife in terms of a hypothetical case, the respondents make available the inference that these practices are instances of a general, recurrent, routine pattern or 'script'.

Furthermore, in extract 9, use of the verb 'will' in 'it's very logical that they will, they will do it' (line 880-881) makes relevant the recurrent, predictable 'scripted' nature of having sex with another man or woman when no children are born.

According to Edwards (1994), one function of script formulations is that they normalise practices or events and establish them as not requiring any special account. This indeed appears to be the function of the script formulations in the extracts discussed. By establishing bearing children when married, and taking certain actions when pregnancy is not achieved, like having an extramarital affair or taking another wife, as (cultural) script, these practices become routine, normal and not in need of any additional accounts anymore. The normalising work done by the scripting formulations is sustained by explicit references to the normality of the expectation of pregnancy and forms of marriage breakdown. In extract 7, the respondent states 'normally in a tradition' (line 556) people give you three months. In extract 8, the interpreter explains that 'it's quite normal' for a man to look for another woman (line 1679-1683).

My claims regarding the justificatory function of respondents' accounts are grounded in respondents' orientations to the potentially blameworthy nature of the practices and those engaging in them. In extract 9, the respondent states twice 'I can't blame them' (line 868, 878). In extract 10, the respondent states in his upshot of his account 'there's nothing wrong with that' (line 139). Although both respondents reject the blameworthiness of the practices and those performing them, in so doing, they attend to moral issues of blame as relevant.

The interviewer's and interpreter's questions suggest as well that justification is the relevant interactional business at hand. In extract 7, line 544, the interviewer repeats, with an exclaiming intonation, the time period within which women are supposed to get pregnant: 'three months!'. Thereby she portrays surprise or lack of understanding at best, and disapproval at worst. In extract 9, the interviewer returns to a topic the respondent has addressed before, which she indicates by stating 'about the other solution you mentioned' (line 858). This request for elaboration can be seen as indicating that the interviewer finds the practices addressed not self evident, and thus in need of an account. In addition, in both extracts 10 and 11, the interviewer specifically asks for the respondent's opinion about respectively men going to other women, and a younger brother sleeping with someone's wife. This is another way in which she treats these practices as not self-evident and arguably, as potentially problematic. This is especially the case in extract 11, where the interviewer asks 'do you think it's a good solution', translated as 'do you think about it as a *good* thing' (line 1650). The interviewer and interpreter indicate that the 'goodness' or morality of the practice is, literally, questionable, by asking about it.

4.3 Criticizing forms of marriage breakdown

So far, I have focussed on several ways in which respondents justify various forms of marriage breakdown. However, this does not forestall the possibility that respondents criticise these practices as well. This happens for instance in extract 9, partly displayed again below, and in extract 11.

Extract 4:9 Int. 16 m.d. (expatriate)

858. I Yah, okay hmhm. Yah and ehm about the other solution you mentioned that
859. they may go to another man or to another (.) woman what do you think about
860. that as a solution
861. R Eh well it's not- I mean if you really want to get pregnant you have to have
862. unprotected sex. So in this country it's really not, it's not very smart to have
863. sex with somebody else just to get pregnant.
((some lines omitted))
878. R So. I can't blame them but I don't think it's good.
879. I You understand that they will seek that solution but that's again it's ( )
880. R Yah, no in this culture, in hm- it's very logic that they will, that they will do it
881. that way but it's just risky behaviour

Extract 4:11 Int. 18 gyn. (expatriate) ((respondent has mentioned just before that 'another problem' is that a wife notices that she can't get children from a man, takes another man and gets pregnant from him and that 'that's why Africans always say, don't tell the man that he's infertile'))

73. I Hm and why is that exactly then that you shouldn't tell the man he's infertile?
74. R yah because he disappears and- or the woman will take <u>maybe</u> another one
75. I Which is is considered not to be a good thing then or
76. R Well, fo- maybe for the society it doesn't matter but eh of course yah we
77. probably with our western eyes it's not very good, I don't know, I I have no
78. idea, but.

In extract 9, the respondent criticises 'having sex just to get pregnant' (line 862-863) by saying that 'it's not very smart' (line 862), 'I don't think it's good' (line 878) and by describing it as 'it's just risky behaviour' (line 881). In extract 11, the respondent is asked why you should not tell the man that he is infertile (line 73). He states that one reason is that 'the woman will take <u>maybe</u> another one' (line 74). The interviewer infers that this 'is considered not to be a good thing' (line 75). When the respondent states 'it's not very good' (line 77), he produces a negative assessment.

However, whilst it thus appears possible for respondents to criticise practices like having sexual affairs or taking another 'one', several observations suggest that the provision of a negative judgement is a sensitive issue. First, in both extracts 9 and 11, the responses are delayed. In extract 9, this is because of delays like 'eh' and 'well' (line 861), in extract 11 because of 'well', the cut off 'fo-', 'eh' and 'yah' (line 76). Second, in both extracts the negative judgement is qualified and played down. In extract 9, there is a repair of 'it's really not' into 'it's not very' (line 862) which tones down the negative judgement. In addition, in line 878, the respondent constructs his judgement as personal opinion rather than as a fact: 'I don't think it's good' (Latour & Woolgar, 1986). In extract 11, the respondent plays down his criticism by saying 'it's not *very* good' (line 77), and by qualifying it as ethnocentric: 'with our western eyes' (line 77). In addition, the respondent plays down the significance of his judgement by providing a 'disclaimer' (Hewitt & Stokes, 1975)[30] regarding his own knowledge 'I don't know, I I have no idea' (line 77-78). In so doing, he minimizes the import of his (negative) assessment. Third, in extract 10 the respondent treats his critical assessment as accountable. The beginning of the respondent's negative assessment is cut off: 'it's not-' (line 861), and followed by an

[30] I put 'disclaimer' between quotation marks as Hewitt and Stokes (1975) talk about disclaimers as *prospective* accounts, occurring before the statement they are meant to disclaim or discount. Thus, in a technical sense, 'I don't know, I I have no idea' is not a disclaimer.

insertion of additional information: 'if you really want to get pregnant you have to have unprotected sex' (line 861-862). This information makes relevant the health risks of having an extramarital affair in order to get pregnant, and can therefore be seen as forming an account for the respondent's critical judgement.

Both respondents in extracts 9 and 11 are western, expatriate practitioners. This identity is observable for the interviewer, and made relevant by the respondent in extract 11 when he states 'with our western eyes' (line 77). More tentatively, it can be argued that in extract 9, the respondent's use of the pronoun 'they' in 'they want' (line 875) and 'they will' (line 880) makes relevant his alternative cultural background. The pronoun 'they' evokes a distance which for instance 'you' or 'people' would not. One of the reasons why providing a critical assessment could be sensitive for these particular respondents is that, being western practitioners, they risk being judged as being ethnocentric. I have discussed how the respondent in extract 9, attends to a cultural rationale which makes the practice 'logic[al]' (line 880) and thereby justifies the practice as well as criticizing it. In extract 11 too, the respondent makes relevant the cultural context: 'maybe for the society it doesn't matter'(line 76). This forms a mild justification for extramarital affairs, as it makes relevant that from a local perspective, this is not necessarily a problem. Potter and Wetherell (1992), in their study of the language of racism in New Zealand, have discussed the rhetorical function of 'culture discourse', which in my opinion can be seen as comparable to categorizing practices and perspectives in terms of culture, as seen in the extracts discussed. Potter and Wetherell (1992, p.134) state that 'culture discourse' is 'user friendly': 'it's about being 'sensitive', 'tolerant' and being sufficiently magnanimous and enlightened to 'respect difference' and 'appreciate' others.' It can be argued therefore, that for the western respondents in extracts 9 and 11, attending to the cultural context of extramarital relationships has two functions. In addition to justifying forms of marriage breakdown, it makes available the inference of a certain cultural awareness and openness, and thereby enables them to provide a negative assessment, whilst preventing accusations of being ethnocentric.

4.4 Summary and Discussion

In this chapter, I have shown how respondents construct bearing children as law-like, normative expectation and requirement. They do this by making bearing children into a category bound attribute of certain categories of people, like grown ups and young people, by using verbs like 'must' and 'have to' in relation to childbearing, by pointing out that not bearing children has negative consequences, and employing if-then constructions combined with generic referents. Furthermore, respondents make relevant the cultural context, by means of which they explicitly construct bearing children as a cultural normative requirement.

The construction of childbearing as normative expectation and requirement can be observed in data from interviews with all categories of respondents: indigenous and biomedical practitioners, significant others and people with a fertility problem. However, only one respondent belonging to the category 'people with a fertility problem' referred explicitly to the cultural context in her account. I have shown however, how respondents in this category can draw upon implicit culturally shared understandings regarding the imperative of bearing children (see extract 1).

I have also shown how respondents can criticise practices like engaging in extramarital affairs or 'taking another one', but thereby attend to this as a delicate matter. This can be seen as support for my claims regarding the culturally shared understandings according to which such practices are justifiable, especially because respondents attend to differences in cultural perspectives in their criticism. Both respondents in extracts 9 and 11 are western practitioners, that is, they were born and grew up in western countries and received their medical training there. I would like to point out however that in my opinion it can be assumed that these respondents have, at least to some extent, 'access' to local cultural understandings as they have worked and lived in Malawi for years, and are as such part of the cultural setting.

At one level, my data corroborate some of the findings of the literature on infertility in developing countries. As said, several authors have reported that bearing children is culturally and normatively expected and required in developing countries (Dyer et al., 2002, 2004; Inhorn & van Balen, 2002; Riessman, 2004), and that not bearing children has interpersonal consequences, including marriage breakdown (Gerrits 1997; Papreen et al. 2000; Dyer et al. 2002; Dyer et al. 2004). In addition, I

have shown that respondents identify the cultural norm of bearing children as a rationale which informs practices like extramarital affairs or polygamy. In the literature, consequences of infertility are frequently, implicitly or explicitly, attributed to pronatalist cultural norms of African societies as well.

However, my analysis goes beyond reproducing the findings of other studies on infertility, and provides additional insights. I have diverted from the normal practice of treating participants' references to the cultural normativity of bearing children as representations of a pre-existing cultural norm, which prescribes reproduction and makes people behave in certain ways. Instead, I have examined how respondents actively construct a cultural norm of childbearing in situated interactions, in order to achieve certain interpersonal goals, made pertinent by the interactional situation. This approach ties in with Kitzinger's (2006) plea that the way forward for discursive psychology and conversation analysis is to pay more attention to, amongst other aspects, the production of culture in interaction. My analysis shows that references to the cultural setting can justify forms of marriage breakdown like polygamy and extramarital affairs by providing a rationale, casting the practices as practical solutions, taking away people's agency and turning them into routine, normal scripts. These claims are grounded in empirical observations regarding participants' utterances and the interviewer's and interpreters' questions, which attend to issues of blame and justification as the relevant business at hand.

In a paper based on my PhD data (de Kok, 2005), and in another study on Malawian Christians' accounts about their involvement in their indigenous religion (de Kok, 2004), I have noted as well that respondents attribute certain practices, like women faking pregnancy, or Christians consulting indigenous healers, to the cultural context. In these cases too, justifying and mitigating blame appeared to be the relevant interactional issues. Thus, it appears that constructing practices as based on cultural expectations and requirements is, for Malawian respondents, a culturally available discursive resource to do justificatory work.

Fragments of interviews shown in papers on infertility in developing countries, suggest that also in other studies respondents make relevant the cultural context in order to do similar justificatory work. For instance, Gerrits (1997, p. 46) states in her paper on infertility in Mozambique that 'although the interviewed fertile

women realise that the infertile women feel bad about their exclusion, they say that these cultural taboos have to be respected. If the infertile women do not follow the cultural rules, they or their relatives will get serious (health) problems.' This suggests that these participants attribute their excluding behaviour to cultural 'taboos' and 'rules'. However, to sustain such an analytic idea about the function of this statement, more details are needed about the interactions in which they occur. These are missing, as Gerrits (1997) paraphrases rather than cites the fertile women, and does not display the questions to which the women were responding. In other infertility studies, an understanding of statements as fulfilling interpersonal, interactional functions rather than representing cultural norms is prevented as well by a lack of detail, in particular regarding the interactional context in which responses are provided.

At a more theoretical level, the analysis presented ties in with Parsons' (1951) classic notion of the 'sick role'. According to Parsons (1951), illness is a conditionally legitimate state of deviance, which brings along certain rights dependent on the ill person's adherence to certain duties. One of the duties of sick people is that they ought to attempt to get better. It can be argued that the respondents in my study attend to a 'duty' to remedy their fertility problem when they construct engaging in extramarital affairs, or polygamy or marrying someone else as reasonable, justifiable practical solution. Other studies (Guise, 2005; Parry, 2004), which draw upon conversation analysis or discourse analysis have also noticed how people with health problems attend to duties as set out by Parsons (1951). For instance, Parry (2004) found, in a conversation analytic study of interactions between stroke patients and physiotherapists, that patients forestall that 'failures' to execute certain tasks given are seen as indicative of lack of effort to get better. Similarly, Guise (2005) notes that in interviews, sufferers from stroke and ME inoculate suspicions that they are not motivated, or not trying, to get better. The resonance between analytic observations made in this and other studies, and Parsons' (1951) theory regarding the sick role, can be seen as indication that Parsons identified culturally shared, common sense expectations and understandings regarding 'proper' ways of behaving when 'ill'. These expectations and understandings form a cultural resource for people to deal with the interactional,

interpersonal business at hand, like justifying their engagement in practices which are open to allegations of being immoral or otherwise improper. Considering that Parsons' (1951) work focuses on western societies, it is interesting to see that the common sense rationale he identifies appears to be widespread and shared across cultural settings. It should be noted though, that according to Parsons (1951), people are seen as obliged to seek the help of technical experts, usually physicians, for health problems. In the data shown in this chapter, respondents address solutions which do not involve seeking help of such experts. However, in chapter 6, I will show that respondents also attend to consulting indigenous or biomedical healers as something which is preferable.

It can be argued that the constructions of the cultural normativity of bearing children are evoked by my identity as non-Malawian, western interviewer. Participants can be expected to provide cultural information specifically in an interview with a foreign interviewer because of the principle of 'recipient design' (Sacks & Schegloff, 1979). According to this principle, interactants will design their utterances in such a way that they are understandable for a particular speaker with a certain presupposed knowledge (Sacks & Schegloff, 1979; Ten Have, 1999b). The participants in my interviews can reasonably assume that I, as foreign interviewer, lack certain cultural information, and this can be seen as informing the provision of additional cultural explanations. It seems less likely that respondents will make explicit the cultural context and rationales to justify practices when talking to fellow Malawians: other cultural members can be presupposed to know about cultural expectations and requirements. Second, the references to the cultural context can be seen as evoked by the interviewer because arguably, the interviews function like Garfinkel's (1967) 'breaching' experiments (see chapter 3). As in Garfinkel's experiments, the interviewer breaches taken for granted assumptions and sense making practices by means of her questions. As a result, normally taken for granted cultural rationales and justifications are made visible and available for analysis.

However, whilst it seems likely that in interactions in which there is no foreigner present, cultural understandings will be made less explicit, or less frequently so, this does not mean that they are irrelevant. It seems improbable to me that the cultural requirements and expectations of bearing children are fabricated

specifically for the foreign interviewer. I will return to this methodological issue in the discussion of this thesis.

Practices such as extramarital affairs, divorce and polygamy may have problematic personal and health implications, considering the high rates of STDs and HIV/AIDS in Malawi. Therefore, it seems desirable to discourage such practices. Insights into how respondents can normalise and justify forms of marriage breakdown can thereby be of help, and also have theoretical implications for health promotion approaches. I will discuss such theoretical and practical implications in the chapter 10.

In this chapter, I have shown how people construct failure to bear (enough) children as a problematic deviation from normative expectations, which ought to be solved. People's perceptions of causes of health problems are often deemed important for the actions which they take to solve them. Therefore, in the next chapter, I will examine how men and women with a fertility problem construct causes of infertility.

Chapter 5. Explaining infertility: An interpersonal affair

Many scholars, including those studying infertility, have studied people's illness beliefs, such as those regarding causes. Two main reasons can be discerned for the interest in beliefs about causes, or illness attributions, regarding infertility or other health issues. First, attributions are considered to have implications for how people react to health problems, that is how they cope with and adjust to illness (see chapter 2), and the health seeking behaviour they engage in. This makes knowledge of illness attributions useful for health promotion. For instance, Meera Guntupalli and Chenchelgudem (2004, p.256) note that the Chenchus, an ethnic group in India, rely on indigenous healers for infertility treatment. They relate this to their observations that respondents attribute infertility mainly to the 'curse of God', 'evil spirits' and 'heat of the body', and that 'none of the respondents had knowledge regarding infertility as a biomedical condition'. Therefore, they propose that health education will 'definitely' change people's perceptions and will therefore promote better health seeking behaviour (op cit.).

Second, scholars are interested in people's beliefs about causes because since the 1980s, there has been a growing concern that people's everyday understandings of illness are silenced by the 'voice of medicine', or the biomedical perspective (Mishler, 1984; Lawton, 2003; Prior, 2003; Riessman, 2002). Acknowledging people's own understandings is considered to make health care more client centered and, in non-western countries, culturally sensitive (UNFPA, 1994; Dyer et al., 2002; Gerrits *et al.*, 1999, Upton, 2001), and therefore more satisfactory (Helman, 1985; Clark & Mishler, 1992).

Two approaches to, or conceptualisations of, illness attributions can be discerned. They feature in both the literature on infertility and literature on other health problems. Hence, the following discussion pertains to both bodies of literature. One approach is usually adopted by studies informed by psychological theories, the other by ethnographic studies. In many psychological studies, illness attributions are seen as a first step in a cognitive problem solving approach (Ogden, 1996, see also chapter 2): when faced by a health threat, people form cognitions

about its causes, as well as about other aspects of the illness (Leventhal, Meyer & Nerenz, 1980; 1984). The second approach, often adopted by ethnographers, considers illness attributions as provided by people's culture; illness attributions are collective, cultural interpretations of a socio-cultural group (Bibeau, 1997; Stainton Rogers, 1991). This means that individual members of a cultural group are seen as having, by and large, the same beliefs regarding causes of illness. The following quote exemplifies this stance: 'The Zande people of West Africa have a dual theory of causality, where common-sense proximal causes operate within the context of witchcraft as a distal cause.' (Hogg & Vaughan, 2005, p. 109)

Both approaches have in common that they treat illness attributions as mental templates of behaviour (Bibeau, 1997; Hunt, Jordan, Irwin, 1989; Yoder, 1997). In addition, in both psychological and ethnographic studies, people's illness attributions are normally clustered together in categories, based on similarities in content, as perceived by the analyst. For instance, in infertility studies based on psychological theories, attention is often paid to whether causal attributions can be allocated to categories pertaining to 'self' or 'own actions' or 'chance'. This reflects an interest in people's internal or external health locus of control (Rotter, 1966; Wallston, Wallston, & DeVellis, 1978), which is considered to be related to more and less adaptive coping styles (see chapter 2). Ethnographic studies of infertility commonly focus on categories such as 'God', 'spirits' and 'diseases', at times clustered together in broader categories such as 'personalistic' and 'naturalistic' (Foster & Anderson, 1978), or 'indigenous' and 'biomedical' (see for instance Gerrits et al., 1998).

These common approaches to illness attributions regarding infertility, and health problems in general, have certain shortcomings. First, the idea that attributions are mental templates for, or determinants of, illness behaviours suggests that people believe in one cause (Stainton Rogers, 1991) and that this belief is relatively stable (Bibeau, 1997; Hunt, Jordan, Irwin, 1989; Yoder, 1997). This notion is challenged by empirical findings that people's causal attributions change, and that people can have several, contradictory, beliefs at the same time (Inhorn, 1994; Herzlich, 1973; Williams & Healy, 2001; Stainton Rogers, 1991; Sundby, 1997).

Second, the notion of attributions as informing health behaviours implies that they precede, or are pre-existing to, these behaviours. However, several scholars

propose that explanations should be seen as resources which people can strategically and flexibly employ to achieve certain interpersonal goals, such as rejecting responsibility (Hilton, 1990; Hunt et al., 1989; Stainton Rogers, 1991; Willig, 2000). For instance, regarding infertility, authors have argued that certain explanations, such as the idea that one's infertility is due to witchcraft, can be used to mitigate (responsibility for) fertility problems and the stigma attached to it (Feldman-Savelsberg, 1999; Riessman, 2002; Upton, 2001). If causal explanations are designed to fulfil a social function, they will be, at least partly, created in practices and interactions, rather than pre-existing (Bibeau, 1997; Edwards & Potter, 1992, 1993; Yoder, 1997).

The notion of explanations of health problems as serving interpersonal goals points up a third weakness of common approaches: they tend to be overly rationalistic (Bibeau, 1997; Stainton Rogers, 1991; Yoder, 1997). This is particularly apparent in psychological studies of illness attributions, which are often inspired by attribution theory (Heider, 1958; Kelly, 1967, 1973). Central to attribution theory is the notion that people are 'naïve', lay scientists, who arrive at attributions by carrying out lay versions of statistical analyses of covariance. That is, in order to explain a phenomenon, people analyse which factors co-vary, or co-occur, with the phenomenon. Many ethnographic studies on illness attributions assume as well that they are the outcome of a rational evaluation of information (Yoder, 1997). They commonly assess, explicitly or implicitly[31], beliefs about causes for whether they are, from biomedical perspective, correct. If not, health education is seen as remedy. This means that beliefs regarding causes are seen as dependent on people's factual knowledge and information. However, as said before, the explanations which people provide may be informed more by their social function (Edwards & Potter, 1992, 1993; Hunt et al., 1989) than by people's biomedical knowledge, or the lack thereof.

A fourth shortcoming concerns the role attributed to the social context of attributions. This context is virtually ignored, as in psychological infertility studies, or taken into account in terms of the macro cultural context, as in ethnographic studies of infertility (see chapter 2). These studies tend to attribute too much

[31] As Pelto and Pelto (1997) note, scholars tend to use the term cultural 'beliefs' in contrast to biomedical knowledge.

explanatory power to the socio-cultural context, as they often treat 'culture' as a reified autonomous entity, which imposes meanings on its members (Singer, Davidson & Gerdes, 1988). As a result, heterogeneity in illness attributions is ignored (Stainton Rogers, 1991; Inhorn, 1994). Overall, scholars have paid little attention to the *interactional* context in which explanations of illnesses, including infertility, are offered. Nevertheless, this has been proven to be a particularly appropriate site to examine the interpersonal functions of explanations (Antaki, 1994; Edwards & Potter, 1992, 1993; Horton-Salway, 2001; Gill, 1998).

In this chapter, I will adopt a discursive approach to people's views on causes of infertility. This approach addresses aforementioned shortcomings by examining how people actively and flexibly construct causes in interactions, and thereby deal with the interpersonal and interactional business at hand. It has been fruitfully applied before to causal attributions (Antaki, 1994, 1996; Edwards & Potter, 1992; 1993; Faulkner & Finlay, 2005), and illness attributions (Gill, 2001; Horton-Salway, 2001), but not to attributions regarding infertility. I will focus on the constructions of causes by men and women with a fertility problem, in response to questions about causes of infertility in general, and regarding respondents' own fertility problem. When appropriate, I will draw upon extracts from interviews with other types of respondents as well, such as significant others and practitioners. As initial analysis showed that design of responses to personal and general questions is very similar, I will present analyses of responses to both questions together. In the preliminary analysis, I was struck by re-occurring claims that respondents did not know what the causes are, of their own fertility problem, or of infertility in general. As this is a phenomenon rarely described in the literature, it seemed worth pursuing. Hence, the analysis presented in this chapter, aims to provide novel insights into how both claims regarding causes of infertility *and* claims that one does *not* know about causes, deal with the interpersonal and inferential business at hand.

5.1. Talk about causes: Ambiguity and lack of commitment

The respondent of the first extract which I want to discuss was told that she has a phantom pregnancy. Although there were several physical signs of pregnancy,

medical examinations suggested that there was no foetus. Hence, this respondent's fertility problem differs from other respondents' fertility problems. However, her response to a question about what she thinks is the cause of her problem exhibits a combination of several features, which can be observed in other extracts. Therefore, I want to focus on this extract first.

Extract 5: 1. Int. 22 inf.w ((The respondent had a phantom pregnancy))

556.I	Okay, good. Yah.		
557.	Ehm:, do you have		
558.	any idea what the		
559.	reason is why you (.)		
560.	thought that you had		
561.	a child, that you		
562.	were pregnant and		
563.	had these signs, but		
564.	now there's no		
565.	foetus, do you have		
566.	an idea what might		
567.	be the reason for		
568.	that what might		
569.	cause this, ehm yah.		
570.T		*((cough)) So you think that is*	((cough))Ati inuyo
571.		*was what that caused that*	mukuganiza kuti ndi chiyani
572.		*here you lost the pregnancy*	chimene chapamgitsa kuti
573.		*there is none? Do you think*	panopamuzipeza kuti mimba
574.		*that there is another reason*	palibe? Mukuganiza kuti china
575.		*that caused it? What is it that*	chake chachitika ndi chiyani?
576.		*you think?*	Chimene mukuganizira inuyo?
577. R		*Hhuhu, but the way I think,*	Hhuhu, koma choganizira, ayi,
578.		*no, nothing. [( )*	palibe, Nanga si [( )
579. T		*[what has*	*[*Chachitika
580.		*happened?*	ndi chiyani?
581. R		*I am not sure. I would not be*	Kaya, pamenepo sindingathe
582.		*able to know. Whether it's*	kudziwa. Kaya zamuwanthu
583.		*witchcraft that is what they*	mmene anandiudzira kuman-
584.		*told me at the witch doctor.*	khwalako kuti kapena ndi
585.		*Ye:s ,therefore, I cannot give*	zamuanthu anachita kukutche-
586.		*an answer because because I*	rani. Eehhetu, diye pamenepa
587.		*am a patient. I would say that*	sindingayankhe siine munthu
588.		*this is a disease. To say, all of*	odwala. Pamenepa nanga si
589.		*a sudden the pregnancy is*	matenda amenewo. Nanga mi-
590.		*gone, this should be(.) human*	mba osaoneka si matenda
591.		*beings' (.) deeds (witchcraft).*	amenewo akupweteka mwina
592.		*Maybe it's some jealousy that*	anthu kapena kuja(.) anthu ku
593.		*the pregnancy disappears.*	(.) chiwembu bayo (mamba-
594.			yo) kuti isaoneke pena basi.
595.T	She's just thinking of		
596.	(.) other people,		
597.R	Hmhm		
598.I	hmhm		
599.T	that maybe they		
600.	have done this.		

601.I Hmhm
602.T It's people.
603.I Okay.
604.T Through witchcraft
605.I Hmhm
606.T Yes
607.I okay
608.T She's thinking so.

The interviewer asks whether the respondent has 'any idea what might be the reason' (lines 565-567) for her phantom pregnancy, which is translated as 'Do you think that there is another reason that caused it? What is it that you think? (lines 573-575). There are three features of the respondent's reply, which I would like to note. First, the respondent denies twice that she has an idea about 'why the pregnancy is gone'. In line 577, she states 'the way I think, no, nothing', and in lines 581 to 582, 'I would not be able to know' (line 567). Second, the denials of knowledge co-occur with several descriptors of potential causes: 'whether it's witchcraft' (lines 582-583), 'I would say that this is a disease' (line 587-588), 'this should be (.) human beings' (.) deeds' (lines 590-591), and 'maybe it's some jealousy' (line 592). Thus, the respondent's response regarding what has made 'that the pregnancy has gone' is ambiguous, in that she both claims not to know what the cause is *and* identifies potential causes. Third, the respondent's descriptions are marked as uncertain by her statement 'I am not sure' (line 567) and by 'maybe' (line 576).

Both the ambiguity and uncertainty make clear that it would be difficult to assess the 'illness attributions' for the extent to which they are in line with biomedical facts, to allocate them to one specific category of illness beliefs, or to see them as behavioural templates. The extracts below exhibit (extracts 2 to 4) similar features.

Extract 5:2. Int. 5 inf. m

453.	I	What do you		
454.		think is in you and		
455.		your wife's case the		
456.		cause of failure, the		
457.		cause of the failure,		
458.		of your failure, to		
459.		have children.		
460.	T		*She says, what caused all*	Akunena kuti inuyo chimene
461.			*the problems with you?*	chinapangitsa zonsezi ndi
462.	R		*That we should not have*	chiyani?
463.			*children?*	Kuti tisakhale ndi ana?
464.	T		*Hm*	Hm
465.	R		*U:h I do not know the*	U:h panopa sindimachidziwa
466.			*real reason but maybe I*	koma kuti mwina
467.			*think that maybe I have*	ndamangoganiza kuti mwina
468.			*sex with my wife maybe*	kapena ndi ndimagona ndi
469.			*maybe before she finished*	mkazi uja mwina mwina
470.			*her menstruation.*	asanathe kumene ku mwezi
471.			*I just think so.*	kapena kuti. Ndimangoganiza
472.				choncho.
473.	T	He's trying to say		
474.		that, maybe, he		
475.		sleeps with the		
476.		woman, wi- that is		
477.		not quite clea-		
478.		clean, due to		
479.		menstruation period.		
480.	I	hmhm		
481.	T	Maybe, nearer to		
482.		menstruation period		
483.		or just after, soon		
484.		after menstruation he		
485.		sleeps with the- her.		
486.	I	hmhm		
487.	T	Maybe, he's		
488.		thinking that is the		
489.		cause.		

Extract 5:3 Int. 42 inf w

612.	I	Yah. Yah, okay, thank you, ehm: ((cough)), so: (2) yeah ·hh (1.5) w-
613.		why do you know in general, in general, why do you think that people
614.		sometimes fail to bear children, do you have any idea about possible
615.		causes of that?
616.	R	(2.5) Uh- hh there are some causes, but e:h I don't know. Ehm.
617.		Because, some people are, they're just, they are barren like that. For
618.		them not to have children, they are barren.
619.	I	They are <u>born</u> like that.
620.	R	Eeh ((yes)) like that. Some people can be: failing to have children
621.		because of: maybe: they were (1) they suffered from some diseases,
622.	I	Hmhm
623.	R	Yes.

Extract 5:4 Int 2 inf m ((respondent spoke some English, but the interpreter was present in order to translate when necessary))

147.	I	Hmhm. Ehm,		
148.		((cough)) why do		
149.		you think that that		
150.		people sometimes		
151.		fail to have children.		
152.		Do you- what do		
153.		you think can be the		
154.		causes of that.		
155.	R	Yah,		
156.	T		*What are the causes that*	Chimachititsa ndichani kuti
157.			*perhaps people do not bear*	mwina munthu asakhale ndi
158.			*children?*	mwana?
159.	R	Maybe,		
160.	T		*Maybe because of sickness?*	Mwina ndi matenda?
161.	R	It's problem of		
162.		nature (the other		
163.		hand)		
164.	I	Hmhm.		
165.	R	ya:h, and it can be		
166.		also that our		
167.		problem maybe we		
168.		have a disease,		
169.	I	Hmhm		
170.	R	Which can make,		
171.		not which can not		
172.		cause us to to have		
173.		a child.		

In extract 2, the interviewer's question concerns causes of the respondents' own infertility problem, as in extract 1. In extracts 3 and 4, the respondents are asked about causes of infertility in general. A first observation which I want to make is that the responses are delayed. This is most clearly the case in extract 3, where there is a long pause of 2.5 seconds before the respondent starts her response to the interviewer's question (line 616). Furthermore, there are three uh-like utterances in line 616: 'Uh-', 'e:h' and '(ehm)', and an out breath which delay the response. In extract 4, the response is delayed because of 'yah' (line 155) and 'maybe' (line 159), which form false starts, in that they are not immediately followed by identification of a cause. Also the elongated 'Ya:h' (line 165) forms a delay.

The respondents were non-native speakers of English, which could at least partly account for the delays. However, as delays do not always occur, it can be argued that when they occur in responses to particular questions, this suggests that the question is in some way sensitive or problematic. This argument is sustained by the observation that in extract 4, the interpreter takes the false starts as indicating that

the question forms a problem for the respondent. After the respondent's 'yah' (line 155), he translates the question into Chichewa, thus attending to the possibility that the respondent cannot answer due to a language problem. Then, after the respondent's 'maybe' (line 159), the interpreter suggests 'sickness' as a possible cause. Again, the interpreter attends to the possibility that the respondent needs help in answering the question.

The responses in extracts 2 to 4 exhibit three features which I have noted in extract 1 as well. First, the explanations of infertility offered are marked as uncertain by 'maybe'. This occurs in extract 2 four times, in lines 466 to 469, in extract 3, in line 621, and in extract 4, in lines 159 and 167. Second, the respondents in extract 2 and 3 deny knowledge of causes, before identifying potential causes. In extract 3, the respondent states at the beginning of her response 'I don't know' (line 616). In extract 2, the respondent states 'I do not know the real reason' before identifying a potential cause. These claims can be seen as a disclaimer, of the kind which Hewitt and Stokes (1975) have called 'hedging'. Hedging signals a minimal commitment to a forthcoming statement and openness to receive discrepant information (op cit.). A classic example of hedging is 'I am not an expert, but [claim]'. Thus, the hedging in extracts 1, 2 and 3 signal a certain lack of commitment to the explanations of infertility which the respondents put forward.

Note that also by the aforementioned constructions of uncertainty, respondents establish of a lack of commitment to their explanation. This goes as well for a third feature of the response of extract 2. The respondent constructs his response as a personal opinion by saying: 'I think' (line 466-467), and 'I just think so' (line 471). Thereby he makes his claim contingent on his thoughts, rather than constructing it as fact (cf. Latour & Woolgar, 1986).

It appears then, considering the ambiguous and non-committal nature of respondents' explanations, that making claims about causes of infertility is in some way problematic. Hewitt and Stokes (1975) argue that disclaimers like hedging have as function to ward off negative typifications which may result from a forthcoming verbal action. This suggests that the function of the various displays of a lack of commitment to the factuality of their claims is to ward off potential, negative

inferences which claims about causes of infertility may make available. I will return to this issue in a later section.

5.2 Doing 'not knowing', treated as reluctance to tell

I have noted respondents' claims of not knowing in extracts 1 to 3. In this section, I will examine 'not knowing' responses in more detail. I will re-examine extract 1, in addition to the following extracts 6 and 7.

Extract 5: 1 Int. 22 inf.w

573.	T	*Do you think that there is*	Mukuganiza kuti china chake
574.		*another reason that caused it?*	chachitika ndi chiyani?
575.		*What is it that*	Chimene mukuganizira
576.		*you think?*	inuyo?
577.	R	*Hhuhu, but the way I think,*	Hhuhu, koma choganizira, ayi,
578.		*no, nothing. [( )*	palibe, Nanga si [( )
579.	T	*[what has*	[Chachitika
580.		*happened?*	ndi chiyani?
581.	R	*I am not sure. I would not be*	Kaya, pamenepo sindingathe
582.		*able to know.*	kudziwa.

Extract 5:6 Int. 12 inf.w

886.	I	So <u>why</u> people	
887.		become infertile, why	
888.		they,	
889.	T	*Okay. She is saying, what*	Okay. Akunena zoti chipangitsa ndi
890.		*causes a person infertile, the*	chiani kuti munthu usabereke
840.		*causes that make people not to*	zifukwa zake zimene zimapangitsa
841.		*have children like you.*	anthu ena asabereke ngati inuyo.
842.	R	*A:: but the problem in my*	A:: koma zimene zimavuta kuthupi
843.		*body I cannot know, one can*	iwe sumathanse kuziziwa iyayi
844.		*go to the traditional healer*	umathanso kupita kwa sing'anga
845.		*who can tell you that they*	achikuda akhonza kukuuza kuti
846.		*made you infertile during the*	anakuononga kovinidwa kupita
847.		*girls initiation, when you go to*	kuchipatala akhonza kukuuza kuti
848.		*the hospital they can tell you*	uli ndi vuto apa monga ndinapita
849.		*that you have a*	kuchipatala anandiuza kuti ndiri ndi
850.		*problem here.*	vuto apapa.
851.	T	*Hm*	Hm
852.	R	*Yes.*	Eeh.
853.	T	Okay, (they're)	
854.		saying that when	
855.		they go to traditional	
856.		healers they say that	
857.		you have got a	
858.		problem, maybe just	
859.		because- in African	
860.		countries, people-	
861.		especially girls, are	
862.		taken to go somewhere	
863.		else and be advised.	
864.	I	Hmhm	
865.	T	Yes. In so many	

866. cases they do some
867. thing, I don't know it
868. properly but they do
869. something maybe
870. that they can affect
871. them in the stomach.
872. And when they,
873. when she went to
874. ehm doctor, he told
875. her that, ehm you
876. have got a problem
877. inside the stomach.
878.I Okay.
879.T Meaning that, there
880. are two different
881. issues,
882.I ◦oh◦
883.T the traditional
884. healer and the
885. doctor.
886.I [Okay
887.T [yah

Extract 5:7 Int 3. inf.w ((respondent has just answered 'at first I was suffering from asthma' in response to the question '*What do you think can cause that problem, the problems that you people face'))*

294.	T	*Not you, she says here in the*	Osati inuyo. Ngawa wawojo.
295.		*village, maybe you hear or*	Akuno ata akunokuno eti, kumu-
296.		*you know what makes a*	sikuno mwine pasawaga yasapi-
297.		*person to fail to have*	kanaga kapena yasamanyira-ga
298.		*children either yourself or*	mundu kuti alepele kuti akole
299.		*somebody else what people*	mwanache. Kanga wawojo kanga
300.		*actually know that when*	wane wakwe myoyo yasa yasama-
301.		*one does such* and *such can*	nyika wandu kuti aa kutenda yanti
302.		*make somebody fail to have*	yanti mpakana ilepeleche kuti mun-
303.		*a child. Yes, that is what she*	dui atende chichi aa atame nimwa-
304.		*is* asking *ahhehe*.	nache, aweleche. Eya ni yakuusya
305.			ahhehe
306.R		*Hhuhu, about that I cannot*	Hhuhu, pele ningambata
307.		*know.*	kumanyilira
308.T1		*The ones that you just hear,*	Yasagambaga kuyipikana basi.
309.		*not that you know them but*	Ngawa yakuti yakuyimanyilira,
310.		*you just hear may be. Be*	yakusapikanaga mwine mwakwe.
311.		*free to say it not that=*	Agopochetu ngawa yakuti
312.			chichichi. Pana kuti une amu,
313.			atameje wagopoka chilu=
314.T2		*=Hhuhu*	=Hhuhu
315.R		*Hhaha*	Hhaha
316.T1		*Feel free .*	Feel free
317.T2		*Yes ( )*	Eeh ( )
318.T1		*hhuhu*	Hhuhu
319.R		*Yes:*	Eya:
318.T1		*It is just a matter of*	Aku kungulukape. Ngawa kuti pana
319.		*chatting. There are no other*	chifukwa chine chakwe.
320.		*reasons. Just chatting.*	Kungocheza chabe.

((after several more probes respondent identifies witchcraft as potential cause))

Like the respondent in extract 1, the respondents in extracts 6 and 7 deny knowledge of causes. In extract 1, the respondent claims 'Hhuhu what I think, nothing' (line 577) and 'I would not be able to know' (line 562). The respondent in extract 6 states 'A::h but the problem in my body I cannot know' (line 842)'. The respondent in extract 7, when asked specifically about fertility problems of 'not you' but people 'here in the village', states 'about that I cannot know' (306-307).

The denials come across as emphatic. This first of all because the respondents in extracts 1, 6 and 7 point at the impossibility of knowing about the cause of their fertility problem: 'I *would* not be able to know' (extract 1, line 581-582), 'the problem in my body I *cannot* know' (extract 6, line 842) and 'About that I *cannot* know' (extract 7, line 306-307).[32] This makes the denials stronger than a phrase like for instance 'I don't know' would.

Second, the respondent in extract 6 accounts for her not knowing. She states that the traditional healer can tell you that 'they made you infertile during the girls initiation', whereas 'when you go to the hospital they can tell you that you have a problem here' (lines 843-850). Thus, the respondent attributes her not knowing to the lack of agreement between two health practitioners. This is reflected in the interpreter's upshot: 'meaning that, there are two different issues', namely 'the traditional healer and the doctor' (lines 880-886). The account warrants the respondent's claim regarding her lack of knowledge, making it more persuasive.

Third, in extract 1, line 578, the respondent uses an extreme case formulation (ECF) (Pomerantz, 1986), which is a reference to an event or object which invokes its maximal or minimal properties. The respondent uses the ECF 'nothing': 'what I think, nothing' (line 562). This makes the denial emphatic. As Pomerantz (1986) points out, one function of ECFs is to provide the strongest version of a claim in case of a sceptical audience. Arguably, the respondent has reason to suspect that the interviewer may doubt her denial of knowledge, as her question about causes of infertility implies an assumption that the respondent may know about causes.

[32] Some may take issue with this claim based on detailed grammatical features of translated data. However, I asked professional translators to verify the relevant translations. They confirmed that respondents use in their denials forms of the verb 'can'. Hence, 'I cannot know' or 'would not be able to know', rather than ' I don't know', appears to be the most adequate translation. I will address translation issues in the discussion of this thesis (chapter 10).

Therefore, the ECFs appear to bolster the denial against scepticism regarding the respondents' lack of knowledge.

Edwards (2000), drawing upon Pomerantz' work, has pointed out that ECFs make claims hearably extreme and nonliteral, that is, they are offered and received as performative descriptions which fulfil a certain function, rather than as accurate descriptions of a state of affairs. Therefore, it seems more fruitful to examine a statement like 'I know nothing' for its rhetorical and interactional function, rather than taking it literally. This is suggested as well by the reactions of the interpreters in extracts 1 and 7 to the respondents' claims. Significantly, both pursue a response after the respondents' claims of not knowing. In extract 1, the interpreter repeats her question after the respondent's denial, asking about 'what has happened' (line 563), that the pregnancy is gone. In so doing, she treats the respondent's denial as a reluctance to tell, rather than as a literal, straightforward display of lack of knowledge. In extract 7, the interpreter attends to a reluctance to identify causes of infertility on behalf of the respondent as well. More specifically, he orients to this reluctance as being based on issues of accountability, as he pursues a response by minimizing the respondents' accountability for her claims. He does this first of all by enabling the respondent to use a form of 'distanced footing' (Potter, 1996, p.148). The notion of footing (Goffman, 1981) refers to the different possible relationships between a speaker and that which he or she reports. For instance, a speaker can be the composer and origin of a story, or merely an animator who reports someone else's story (Goffman, 1981). In extract 7, the interpreter's phrase '*The ones that you just hear, not that you know them but you just hear maybe'* (line 308-310) makes the respondent merely the animator of others' claims rather than the source of any forthcoming claims. As Potter (1996) points out, distanced footing diminishes people's accountability for their claims: people are normally not held accountable for claims that are merely reported.

Second, the interpreter plays down the respondent's accountability by constructing the setting as inconsequential. He does this by using phrases as 'it is just a matter of chatting' (line 318-319) and 'Just chatting' (line 320), as 'chatting' is a word with playful connotations, and 'chats' do normally not have problematic consequences. In addition, by stating 'there are no other reasons' (line 320-321), the

respondent denies that the question is based on a special reason or interest of any of the participants to the conversation. By implication, the respondent suggests that there are no consequences attached to the respondent's claim. Moreover, also by means of the probe 'be free to say it' (lines 311 - 312, 314), the interpreter orients to, and rejects the relevance of, any concerns for potential implications on behalf of the respondent, which would make her not 'feel free'. Note that the interpreter is successful; after several probes the respondent identifies a potential cause.

Thus, the emphatic design of respondent's denials and interpreters' probes suggest that the respondents have an interest (cf. Edwards & Potter, 1992, Edwards, 2000) in *not* being seen as knowledgeable about the causes of their fertility problem, and that respondents' 'doing not knowing' deals with some interactional and inferential business at hand.[33] Considering the non-committal nature of the respondents' claims and the hedging, this 'business' appears to be related to issues of accountability and certain potential consequences attached to making claims about causes.

5.3 Interpersonal issues at stake

The question remains what sorts of issues of accountability and what kind of potential consequences respondents have to deal with when talking about causes. In this section, I will discuss two issues which appear to form a problem which respondents, when talking about causes, have to deal with.

5.3.1 Lack of entitlement to know

The next three extracts, together with extract 1, provide some more insight into one of the issues at stake. For ease of reference, the relevant parts of extract 1 are reproduced below.

Extract 5:1 Int.22 inf.w

581.R	*I am not sure. I would not be*	kaya, pamenepo sindingathe
582.	*able to know. Whether it's*	kudziwa. Kaya zamuwanthu
583.	*witchcraft that is what they told*	mmene anandiudzira
584.	*me at the witch doctor. Ye:s*	kumankhwalako kuti kapena

[33] I use the phrase 'doing not knowing' to highlight the performative function of the respondents' claims that they do not know about causes. I do not mean to suggest that respondents 'merely' pretend to not know; I am not interested in whether respondents' statements are 'true' or not.

585.		*,therefore, I cannot give an*	ndi zamuanthu anachita
586.		*answer because because I*	kukutcherani. Eehhetu, diye
587.		*am a patient. I would say that*	pamenepa sindingayankhe
588.		*this is a disease.*	siine munthu odwala.

Extract 5:8 Int 12 inf. w

850.I	Okay. Yah. ·Hh and		
851.	what sorts of diseases		
852.	are those, which can		
853.	make people not bear		
854.	a child.		
855.T		*She is saying what kind of*	Akunena kuti ndi nthenda yanji
856.		*disease is it which can cause a*	imene ingapangitse munthu kuti
857.		*person not to have a child?*	sangathe kukhala ndi mwana
858.			imene mukuyidziwa?
859.R		*When we go to the hospital they*	Titapita kuchipatala amatiuza
860.		*tell us of sexually transmitted*	kuti kutenga matenda odzera
861.		*diseases like gonorrhea,*	munchiwerewere monga
862.			chizonono,
863.T		*◦Hm◦*	◦Hm◦
864.R		*syphillis,*	chindoko,
865.T		*◦Hm◦*	◦Hm◦
866.R		*billharzia (2) eh, and other*	likodzo (2) eh ndi matenda ena.
867.		*diseases*	
868.T	Okay.		
869.R		*Hm*	Hm
870.T	What she knows is		
871.	that when they go to		
872.	the hospital, they tell		
873.	her that (well), the		
874.	problem that when		
875.	somebody doesn't		
876.	have a child is that		
877.	maybe because of the		
878.	SID, STD diseases		
879.	[like		
880.I	[hmhmn		
881.T	gonnorhea, syphilis		
882.I	Okay		
883.T	Hm which [causes		
884.I	[yah		
885.T	some people not to		
886.	having a child.		
887.I	Okay yah yah. Uhu.		
888.T	Hm		

Extract 5:9 Int. 39 Inf. m

486.	I	Hm, okay. Yah. Ehm, do you have any idea in general why
487.		people fail to bear children sometimes? Do you have any idea
488.		about possible causes?
489.	R	Ehm (3) yes, now just by experience, eh (I mean) education and
490.		just because I went to school,
491.	I	Hm
492.	R	we just, we were just told (by) our teacher that maybe, (when one) is miscarried,
493.	I	Uhu

494. R Ehm, eh having I mean abortions,
495. I uhu
496. R that's one. Many. Many is abortions
497. I Okay
498. R for: women.
499. I I see
500. R And for men, eh STDs.
501. I uhu
502. R Eh, sexually transmitted diseases
503. I Yah

As discussed, the respondent in extract 1 puts forward several potential causes of her fertility problem. The respondents in extracts 8 and 9 identify causes for infertility in general: 'sexually transmitted diseases like gonorrhoea, syphilis, bilharzia and other diseases' (extract 8, lines 862-863), 'abortions' (extract 9, line 494) and 'STDs' (line 500).

Noticeable is that all respondents identify the source of their knowledge, 'that is what they told me at *the witchdoctor*.'(extract 1, line 568, 569); 'when we go to *the hospital*, *they* tell us' (extract 8, line 859-860) '*education* and just because I went to *school*' (line 489 -490) and 'our *teacher*' (extract 9, line 492). Note the repair of 'experience' into education and school (line 489-490). This suggests that identifying one's education as source of knowledge does some interactional work, which making relevant personal experience does not.

The idea of 'category entitlement' (Edwards & Potter, 1992; Potter, 1996; Sacks, 1979) sheds some light on the function which identifying an external source of knowledge fulfils. Several authors have pointed out that people have shared, cultural, normative understandings regarding the knowledge which categories of people can be expected to have (Drew, 1991; Edwards & Potter, 1992; Sharrock, 1974). People in hospitals and witchdoctors can be expected to have such an entitlement to knowledge about illnesses and their causes. Teachers too, can be expected to be granted such an entitlement by virtue of a category attribute of being knowledgeable in general. It appears that by identifying 'authorized' others as the source of their knowledge, respondents take into account that they, unlike these (witch)doctors and teachers, do *not* have an entitlement to put forward knowledge about causes of infertility (cf. Drew, 1991). This claim is supported by the observation that the respondent in extract 1 states in lines 585 to 587: 'therefore, I cannot give an answer because I am a patient'. She thereby explicitly attends to her

lack of entitlement to (display) knowledge about causes.

Additional support for my claim that lack of entitlement to knowledge about causes can be an issue for respondents comes from interviews with two significant others, who are both not working as a health practitioner. They can be seen to be dealing with this entitlement issue as well. Consider the extracts below.

Extract 5:10 Int.35 s.o

882. I Yeah. Yah I see. Okay. Ehm, what do you think in general the main causes of
883. this issue of infertility here, of failure to bear children?
884. R Hm:, eh since I'm not good in eh e:h medical manners, but eh=
885. I =It doesn't matter ( ).
886. R You are just ask, me about my opinion.
887. I Yah, yah.

((respondent lists three causes: 'just created like that', diseases 'like these STDs' and witchcraft))

Extract 5:11 Int.13 s.o

862.I	Okay, yah. Do you		
863.	yourself happen to		
864.	know in general, not		
865.	specifically for your		
866.	daughter, but do you		
867.	know of any diseases		
868.	maybe which make		
869.	people fail to have		
870.	children?		
871.T		*Are there (.) maybe other*	Pali (.) mwina matenda ena, amene
872.		*diseases, that you know of, that*	mukuwadziwa, amene angaa (.) zi
873.		*may (.) it (.) it may be possible,*	(.) zikhoza kutheka, kuti mwina,
874.		*that may be, were the cause for*	ankachitisa mwana wanuyo kuti
875.		*that child of yours not to have*	asakhale ndi
876.		*children?*	ana?
877.R		*Ah (1) those diseases I cannot*	Ah (1) matendawo sinditha
878.		*know them, no.*	kuwadziwa, iyayi.
879.T	Okay, she's saying		
880.	that she doesn't		
881.	know the diseases.		
882.I	And what do you		
883.	think about certain		
884.	more spiritual or		
885.	traditional reasons?		
886.	ehm, [are		
887.		*[But maybe, perhaps if she goes*	[Koma mwina kapena atapita ku
888.		*to the Hospital there, they can*	Chipatala uko, akhoza kuwayeza
889.		*be able to examine her that*	kuti chimene chikulepheretsa, nc
890.		*what makes her fail, is this and*	chakuti-chakuti!
891.		*this!*	
892.T	She's saying that		
893.	maybe they can with		
894.	people at the hospital,		
895.	they can maybe know,		
896.	the problem.		

Before the respondent in extract 10 identifies several potential causes of infertility, he provides a disclaimer (Hewitt & Stokes, 1975), by means of which he minimizes his commitment to the truth status of his claims about causes of infertility. In line 884, the respondent states 'since I'm not good in eh e:h medical manners', by means of which he makes relevant that he is not an expert in medical issues. Hence, the respondent can be seen to orient to a certain lack of expert entitlement to make factual claims about causes. By means of the phrase 'you are just ask, me about my opinion' (line 886), the respondent minimizes commitment to his claims as well, by constructing them as 'merely' an opinion (Latour & Woolgar, 1986).

In extract 11, the respondent emphatically denies that she 'cannot' know about diseases which cause infertility. She adds to this denial 'But may be perhaps if she goes to the hospital there, they can be able to examine her that what makes her fail, is this and this!' (line 887 to 890). She thereby makes relevant a contrast, marked by 'but', between herself and people at the hospital, who *are* able to know about the causes of her daughter's fertility problem.

Thus, extracts 10 and 11 are two additional examples of extracts in which respondents appear to take into account that they lack a certain common sense authority to make claims about causes.

5.3.2 Sensitivities in talk about STDs and abortions

Whilst claiming knowledge about causes of infertility appears to be problematic in general, there may be additional problems with identifying specific causes, like STDs or abortions. Consider extracts 12 to 14.

Extract 5: 12 Int. 12 inf.w

876.	I	Okay, yah. Ehm, do		
877.		you know in general,		
878.		when people fail to		
879.		have children, do		
880.		you have <u>any</u> idea		
881.		about why that might		
882.		be, what might be the		
883.		causes of this issue.		
884.	T		*And other people whom you*	Ndipo anthu ena mungathe
885.			*know, what would be the causes*	kudziwa zokuti kodi ndi zfukwa
886.			*of infertility, not you but other*	zinazimene mumadziwa?
887.			*people, are there any causes*	
888.			*you know?*	

889.	R		*Some causes they say sexually*	Zifukwa zina amati kutenga
890.			*transmitted diseases (infections)*	matenda mwina chiberekero
891.			*which spoil the womb/uterus*	chinaongeka koma ine
892.			*but I never had such diseases,*	sinatengepo matenda iayi.
893.			*no.*	
894.	T	She's saying that, sa:		
895.		there can be: some,		
896.		diseases that they can		
897.		cause somebody to:		
898.		not bear a child but.		
899.		She has never had		
900.		such diseases.		
901.	I	Hmhm		
902.	T	Hm.		

Extract 5: 13 Int.2 inf.m

199.	I	Hm I see, yah okay. Ehm ((cough)) do you have any idea whether: (.)
200.		ab↑ortion for example (.) here, in Malawi, sometimes also cause [it.
201.	R	[Yah yah.
202.	I	Hm.
203.	R	But eh my my wife didn't have abortions.

Extract 5: 14 Int 39 inf.m ((respondent has mentioned before abortions as a main cause for women's infertility))

537.	I	Okay, uhu, I see. Yah. And do you have any idea – you already said that in
538.		your case you think that it might be, that it's your wife who has the problem
539.		of (.) ehm infertility, that she is the one who has some kind of problem.
540.	R	Ehm, about that I do eh I talked to my wife,
541.	I	uHu
542.	R	and she said that she has never done that.
543.	I	Uhu, done what?
544.	R	About the abortion, something like that. But eh maybe there should be just a
545.		problem somewhere. But as for her, I will try to ( ) we had a negotiation,
546.		and we already negotiated. We had the negotiation whereby she said ah I
547.		have never done that in my life.

In extracts 12 and 13, the respondents acknowledge that respectively sexually transmitted diseases and abortion are potential causes of infertility. The respondent in extract 14 mentioned just before the extract that abortions are the main cause for women's infertility. All three respondents point out, spontaneously, that these causes are *not* the reason for their own or their wives' fertility problem. In extract 12, the respondent states 'but I never had such diseases' (lines 892-893), in extract 13, the respondent adds 'my wife didn't have abortions' (line 203). In extract 14, the interviewer refers to the respondents' claim that his failure to have children is due to his wife having 'some kind of problem' (line 539). In response, the respondent points out that his wife 'has never done that'. Asked for clarification (line 543), the respondent makes clear that he is referring to 'the abortion' (line 544).

The respondents make their rejection of abortions or (sexually transmitted) diseases as cause of their infertility persuasive, and they do so in several ways. First of all, the respondent in extract 15, makes clear that his claim is grounded in a discussion about the abortion issue with his wife: 'about that I do eh I talked to my wife' (line 540); 'we had a negotiation'; 'we already negotiated'; 'we had the negotiation whereby she said' (lines 545-547). By making clear the basis of his claim, the respondent makes it more convincing. Second, the respondent uses active voicing: 'she said 'I have *never* done that in my life' (lines 547). As Wooffitt (1992) has shown, active voicing can be used to warrant the factual status of a claim, and thereby forestalls sceptical responses. Third, the respondents in extracts 12 and 14 use the extreme case formulation 'never': 'but I *never* had such disease' (extract 12, line 892), 'she has *never* done that' (extract 14, line 542) and 'I have *never* done that' (extract 14, line 547). In extract 14, the addition 'in my life' (line 547) strengthens the ECF 'never' by making clear that the claim is based on the whole life span rather than a particular time period. The ECFs give maximum strength to the claims that the respondents' fertility problems are not due to diseases or due to the wife's abortions, and make them thereby more persuasive (Pomerantz, 1986).

As mentioned before, Pomerantz (1986) pointed out that ECFs are used especially when faced with a sceptical audience. In these extracts, it is conceivable that the interviewer is sceptical regarding the truth of the respondents' claims. For, all three the respondents claim that either STDs or abortions can, in principle, be a cause of infertility. This logically implies that their own fertility problem may be due to these causes. This is especially the case in extract 14, where the respondent has mentioned before that abortions are the main cause of infertility in women, *and* that his wife is the reason for their own childlessness.

The rhetorically strong claims that one has not contracted STDs, or that one's wife has not had an abortion, can be seen as a way of dealing with a potential problem: displaying knowledge about causes of infertility can make available the inference that one has personal 'experience' with these causes. This appears problematic, first of all because respondents' persuasive denials. As Edwards (2000) has pointed out, ECFs are used to highlight a point, and in so doing, can be taken to display the speaker's investment in the point. Hence, by emphasizing that they do

not have personal experience with STDs or abortions, the respondents display an investment in coming across as such. In other words, they attend to being seen as having personal experience with these causes of infertility as undesirable.

Second, it seems conceivable that STDs and abortions have problematic connotations, for instance because they are associated with problematic activities, such as promiscuity.

5.4 Summary and Discussion

I have shown that claims about causes of infertility, in general or regarding respondents' own fertility problem, can be ambiguous, delayed, marked as uncertain and non committal. This indicates that talking about causes can be problematic, which is suggested as well by respondents' emphatic denials of knowledge about causes of infertility, and interpreters' treatment of these denials as reluctance to tell. I have pointed at two interactional and inferential issues which respondents appear to take into account. First, respondents attend to a lack of entitlement to know about causes. Second, respondents appear to take into account that displaying knowledge of particular causes, like STDs or abortions, makes available the inference that they have personal experience with these causes. Respondents treat such an inference as undesirable, and deal with it, by means of their persuasive denials.

My analytic findings shed light on the observation, reported in several other studies, that people indicate that they do not know about causes of infertility (Dyer et al., 2004; Dyer et al., 2004) or other health problems in developing countries, such as tuberculosis (Steen & Mazonde, 1999) and diabetes (Joshi, 1995). In addition, Gerrits (1997) mentions that many respondents expressed doubts about the causes mentioned. Normally, such findings are either given no attention (but see Last, 1986), or it leads to conclusions that people need health education. For instance, Dyer et al. (2004: 962) note that 'several participants' said that they did not know the causes of infertility, that 'lack of adequate knowledge was a central finding', and that as 'men were poorly informed' they have a need for, and attach importance to, medical information (Dyer et al., 2004, p. 964). However, it appears that denials of knowledge of causes are at least in part wyas of dealing with interpersonal and

inferential issues such as lack of entitlement to know about causes. In several conversation analytic studies of doctor-patient interactions in the west, it has been noted as well that patients' orient to a lack of entitlement by attributing explanations to third parties, or displaying a lack of commitment or uncertainty about causes (Drew, 1991; Gill, 1998; Silverman, 1987, see also Kleinman, 1980[34]). Lack of entitlement appears to be of relevance for respondents in Dyer et al.'s (2004) study, considering that some respondents added to their denial of knowledge 'that that they had come to the clinic in order to find out' (Dyer et al., 2004, p. 962). Thus, as Drew (1991) argues, it is important to separate issues regarding asymmetries (e.g. between doctors and patients) in entitlement to knowledge from actual states of knowledge or ignorance. In other words, conversational phenomena, informed by differences in entitlements between doctors and lay people, should not be assumed to reflect an absence of knowledge.

The second interpersonal issue which I have discussed, that claims about causes may make available problematic inferences about oneself, also appears to contribute to an understanding of observations made by other authors. For instance, Gerrits (1997) mentions that although many of her Mozambiquan respondents identified STDs as cause of infertility, and had had a STD themselves, none of them related it to their own infertility. Also in Bangladesh it was found that respondents did not relate their STD, of which they were aware, to their fertility problems (Gerrits et al., 1998). The authors themselves do not attempt to explain these observations. I suggest that they may be understood as being part of a strategy to avoid being seen as infertility due to STDs and related problematic inferences.

The observations regarding the interpersonal functions of claims about causes bring out the problems of rational approaches to claims about causes *and* to claims of not knowing about causes. It should be taken into account that answering questions, and talking, about causes of infertility, in general or regarding one's own fertility problem, is not a neutral, cognitive affair (cf. French, Maissie & Marteau, 2005). Therefore, questions about causes may have different meanings and relevancies for

[34] Kleinman is not a discourse or conversation analysts, and does not talk about category entitlement. Yet, he appears to hint at the same issue when he states that laymen are 'embarrassed about revealing their beliefs' as 'they fear being ridiculed, criticized or intimidated because their beliefs appear mistaken or nonsensical from the professional medical viewpoint' (Kleinman, 1980, p. 106)

research participants than for the researchers. French et al. (2005, p. 1419) rightly point out that researchers' and research participants' 'cross purposes have perhaps resulted in the attributions of patients being explained in terms of ignorance or 'biases' in motivation or processing.'

It should be mentioned that, as discussed in the literature review (chapter 2, section 1.3), other authors have paid attention to the interpersonal function of causal attributions for infertility. Overall, this function is seen as dealing with issues of blame and responsibility and management of the stigma of infertility. The question can be raised whether these claims are sufficiently grounded in the concerns which participants themselves orient to in situated interactions. By examining in more detail content *and* design of explanations (cf. Antaki, 1988), and paying attention to the interactional context of people's explanations, I have provided additional insights into concerns which participants themselves make relevant. This is important as after all, insight into people's own understandings is one of the main motivations for scholars to study illness beliefs, such as those concerning causes, and essential for the development of culturally sensitive services.

There are further methodological, theoretical and practical implications related to the analysis presented in this chapter. I will discuss these in chapter 10.

In conclusion, I have shown in this chapter that the interactional context is relevant for the claims which people make about causes of infertility. My approach thus differs significantly from those which treat attributions as individualistic cognitive entities, or as overly determined by the cultural context. My demonstration of the ambiguity, variability and hesitancy in people's explanations, their non-committal nature, and their interpersonal and interactional function, calls into question the idea of illness beliefs as pre-existing mental templates for behaviour. In the next chapter, I will examine how people themselves explain the actions they take or do not take, and the issues they themselves thereby attend to as relevant for their behaviour.

Chapter 6. Accounting for (not) taking action

Many authors have studied the solutions which people seek for their fertility problem, especially solutions sought from medical sources. In so doing, they have often examined which factors correlate with health seeking behaviour, in an attempt to explain what makes people seek help (see chapter 2). Various individual characteristics have been found to be associated with people's health seeking behaviour, in particular demographic characteristics such as gender and education, and psychological factors, such as beliefs about causes, motivations, and locus of control. Whilst in the west, several studies have examined psychological factors (e.g. anxiety, depression, stress, see chapter 2) which make people stop infertility treatment, in particular IVF, only a few studies of infertility in the developing world discuss why people do *not* seek help for fertility problems. When they do, they focus on practical reasons reported by research participants, such as costs involved (Sundby et al., 1998; Unisa, 1999), treatment not being necessary (Unisa, 1999), or lack of information (Sundby et al., 1998). Sundby et al. (1998) also mention that some of their respondents in their study of infertility in the Gambia relate not seeking (biomedical) care to husband's unwillingness to seek help.

Overall then, studies which examine health seeking behaviour for infertility focus on individual decision makers, whose decisions are dependent on, and caused by a combination of individual demographic, psychological or cognitive characteristics, and practical inhibitors. This is a common approach to health seeking behaviour in general (MacKian, 2003), and can be criticised for several shortcomings. These are similar to those discussed in the previous chapter in relation to common approaches to illness cognitions (see chapter 5). First of all, the focus on individualistic features leads to a neglect of the relevance of the social context for the actions which people take (Crossley, 1998; Marks, Murray, Evans, Willig, Woodall & Sykes, 2005; McKian, 2003; Obermeyer, 2002, Ogden, 1996, Willig, 2000). Second, health seeking behaviour is examined from an overly rational perspective. In these approaches, health seeking behaviour is normally seen as the outcome of a calculation of the behaviour's costs and benefits, based on a systematic evaluation of

available information (Crossley, 1998; McKay, 2003; Obermeyer, 2002; Ogden, 1996, Yoder, 1997). Thereby it is assumed that avoiding health risks is a priority for people (Crossley, 1998; Obermeyer, 2002). Hence, health education is thought to be an appropriate method to change people's health behaviour, the idea being that if people have correct information, for instance about the seriousness or causes of a health problem, they will choose to engage in healthy behaviours (Crossley, 1998; Marks et al., 2005). However, as scholars like Crossley (1998) and Obermeyer (2002) have argued, there are various non-rational, interpersonal issues which seem of relevance for people's health related behaviours, such as a search for pleasure or peer pressure (Obermeyer, 2002; Bajos, 1997), or the moral identities which are related to and evoked by certain behaviours (Crossley, 1998; Obermeyer, 2002). As Crossley (1998, p.39) points out, people's 'decisions to act in certain ways do not conform to rational, logical, value-free ways of thinking, but have their own alternative logic and validity that is related in a complex fashion to the cultural and moral environment in which they live'.

It therefore seems desirable to gain insight into people's *own* rationales and understandings of their actions (Crossley, 1998; Stainton Rogers, 1999), which are likely to inform the actions which they take. According to Crossley (1998), one way to obtain such insights is careful examination of how people talk about their activities. In this chapter, I will present analysis of how people talk about the actions which they have taken in order to solve their fertility problem, often, but not always, in response to questions about their actions (e.g. 'what did you do to solve your problem?'). In the initial stages of analysis, it became apparent that in addition to describing the actions they had taken, respondents address and account for *no*t taking action, or for their discontinuation of action. Since little attention has been paid to this in the infertility literature, I will focus in this chapter in particular on these accounts for inaction. I will show how respondents attend to not taking action as a problematic breach of normative expectations, and account for it in ways which play down their culpability. Hence, the analysis points to the relevance of interpersonal, normative and moral issues in accounts for actions taken *and* not taken in order to solve fertility problems. This challenges models of health seeking behaviour

according to which various reasons for (not) seeking help are part, or the outcome, of rational cost benefit analyses.

6.1 Inaction attended to as problematic

In the first two extracts which I want to discuss, the respondents answer a question about their own (extract 1) or their wife's (extract 2) actions. Note that in extract 2, the interviewer asks the respondent about his wife's view of the cause of their fertility problem. However, in the interpreter's translation this becomes a question about his wife's actions: 'what does your wife do after she has realized that there is no child in the family?' (lines 406-409). As I will show, the responses in both extracts indicate that there is something problematic about not taking action.

Extract 6:1 Int. 2 inf.m

434.	I	Okay yah I see. Ehm have you sought for: any solutions for your
435.		failure, and your wife's failure to have babies.
436.	R	Ehm, yes. I I have (one) solution.
437.	I	Hmhm
438.	R	I just maybe think of going, maybe to some clinic, to help us to have
439.		children.
440.	I	Okay.
441.	R	Yah.
442.	I	Yah. You're thinking about doing that.
443.	R	Yah.
444.	I	Y- you haven't been going there yet.
445.	R	I haven't.
446.	I	Okay. Yah.
447.	R	Yah.
448.	I	Hmhm.
449.	T	( )
450.	R	[But (has to) take maybe. It's the problem of financial (which will be)
451.		(charged by that clinic).
452.	I	Okay,
453.	T	(If they make something to do)
454.	I	yah.
455.	T	yah.

Extract 6:2 Int. 5 inf.m.

401.	I	Okay, I see and what	
402.		is your wife's view	
403.		of the cause of your	
404.		failure to have	
405.		children.	
406.	T	*She says, what does your*	Akuti nanga mkaziyo
407.		*wife do after she has*	amapanga zotani panopo
408.		*realized that there is no*	ataona kuti palibe mwana
409.		*child in the family?*	amene akupeza?
410.	R	*Uh, at the moment she does*	U:h panopa, palibe chimene
411.		*not do anything because*	chilichonse chimene amapa-
412.		*since we failed to get money*	nga kunena kuti sinanga
413.		*to pay at Banja La*	nthawi imene tinalephera

414.		*Mtsogolo*[35] *where we were*	kuti tipeze ndalama kuti
415.		*getting the medicine, we just*	tikalipile kuti ku Banja La
416.		*stopped.*	Mtsogolo kumenen tinapeza
417.			mankhwalako tinangosiya.
418			
419.T	He was taking medicine to		
420.	Banja La Mtsogolo.		
421.I	hmhm		
422.T	So, he: failed to continue.		
423.I	Hmhm		
424.T	Because of shortage of		
425.	money. He thinks if he		
426.	could have continued,		
427.	maybe he would have a		
428.	child.		
429.I	Okay		
430.T	Yah.		
431.I	Is that what (.) your wife		
432.	thinks.		
433.T	Yah.		
434.I	Okay. Hmhm		
435.T	They said if they could		
436.	have money, they could		
437.	have continued to take		
438.	medical (.) drugs, as they		
439.	was doing.		
440.I	Okay		
441.T	Yah		
442.I	But is is-		
443.T	but e- they are now, they		
444.	don't have money to [pay		
445.I	[uhu		
446.T	for [the (.)Banja		
447.I	[↑okay		
448.T	LaMtsogolo		
449.I	Uhu, yah.		

In extract 1, the respondent starts his response to the question whether he has sought for any solutions with a confirmation: 'Yes, I I have (one) solution' (line 436). In the next line, he adds information about the kind of solution: going 'to some clinic' (line 438). However, as the respondent precedes this information with 'I just maybe think of going' (line 438), he implies that going to a clinic is merely a potential future solution. The interviewer picks up on this: 'you're thinking about doing that' (line 442) and 'Y- you haven't been going there yet' (line 444), and the respondent subsequently confirms: 'I haven't' (line 445). Hence, from the response in extract 1 it can be *inferred* that the respondent has not yet taken action to solve his fertility problem, but the reference to inaction is not immediate and implicit.

In extract 2, the respondent refers to inaction as well, as he states that his wife 'does not do anything' (line 410-411) and that 'we just stopped' (line 415-416). The

[35] Banja Lamtsogolo is a Malawian NGO which provides reproductive health services (mainly family planning) and has many clinics in various urban and semi-urban areas of Malawi

reference to inaction is embedded in references to previous action. By saying that 'at the moment' his wife does not do anything (line 410), and that he and his wife 'were getting the medicine' (line 413-415) at the clinic Banja LaMtsogolo, the respondent makes clear that they have taken action in the past. He does this as well by saying 'we just stopped' (line 416-417). The interpreter refers to the respondent's previous action by mentioning that 'he was taking medicine to Banja La Mtsogolo' (line 419-420) and points out, several times, that the respondent did not continue: 'he failed to *continue*' (line 422), 'if he could have *continued*' (line 425-426) and 'they could have *continued* to take medical (.) drugs' (lines 436-438). Thereby the interpreter makes clear that the respondent was taking action at some point, which he does as well when the interpreter says 'as they was doing' (line 438-439).

Both respondents account for their inaction; they explain that they could not take action due to lack of money. In extract 1, the respondent states: 'It's the problem of financial (which will be charged by that clinic)' (line 450-451). In extract 2, the respondent makes clear that 'she does not do anything because since we failed to get money to pay at Banja La Mtsogolo' (line 411).

The observations, that a reference to inaction is not immediate and implicit (extract 1), embedded in descriptions of previous actions (extract 2), and treated as accountable, imply that there is a problem with claiming not to take action. This applies perhaps most to the respondents' provision of accounts for their inaction. In seminal publications, Garfinkel (1967) and Scott and Lyman (1968) have argued that a central function of accounts is to mend a 'problematic', related to a breach of social norms and what is taken for granted (cf. Buttny, 1993). Thus, in accounting for their inaction, respondents can be seen to attend to, and remedy, a breach in normative expectations that they take action in order to solve their fertility problem. Such expectations can be inferred from the interviewer's and interpreter's questions. The question whether the respondent has sought for any solutions (extract 1), displays an assumption that the respondent at least *may* have sought for solutions; otherwise there would be no point asking about it. In extract 2, the assumption that the respondent's wife has taken action is embedded in the interpreter's question, as he asks *what* his wife does, rather than *whether* she has taken any action.

I should mention that not all respondents treat their inaction as accountable. However, these cases are relatively rare; only 3 out of the 11[36] respondents who state not to be taking action do not account for their inaction. All three of these respondents have one or more children, and make this relevant in the extracts in which they mention that they have not taken action. Hence, dealing with expectations regarding taking action appears less relevant to those who have at least one child.

6.2 Playing down culpability for not taking action

Examination of respondents' descriptions of their actions and inaction brings out several features, which appear to fulfil a function of playing down respondents' culpability for not taking action. In what follows I will focus on extract 2 as well as on two new extracts.

6.2.1 'Trying' and doing being motivated

As in extract 2, the respondents in extracts 3 and 4 refer to previous actions, as well as making clear that they are not taking action anymore. In extract 3, the respondent is asked what she did to solve her problem. In extract 4, the interviewer asks the respondent about her relationship with her husband, but in her response, the respondent addresses their attempts to solve their problem.

Extract 6:3 Int 12 inf w.

1136. I	Okay, yah, so what did you		
1137.	do to solve your problem?		
1139. T		*And what did you do to*	Ndiye munapanga chiani
1140.		*solve the problem?*	mutafuna kuti vutolo lithe?
1141. R		*We got the medicine and*	Ineyo tinakafuna
1142.		*while I was still taking the*	mankhwala, tiri pakati
1143.		*medicine, then I found the*	pakudya mankhwala
1144.		*money to take up to the*	ajandimmene ndinapeza
1145.		*hospital because we had*	ndalama kuti tipite
1146.		*intended to go to the private*	kuchipatalako timafuna
1147.		*hospital because the*	chipatala cholipira chifukwa
1148.		*government hospital did not*	chikakhala chipatala
1149.		*give me much attention.*	chakuboma ndinazapita
1150.		*When we went for the first*	koma akungondizengereza.
1151.		*time, to the government*	Titapita ulendo oyamba
1152.		*hospital, they examined my*	anangotenga mphamvu ya
1153.		*husband's sperms only*	bamboyo ndikuyeza

[36] I acknowledge that there are problems in providing counts like this one, as pointed out especially by Schegloff (1993). I will discuss issues of quantification in chapter 10.

1154.		*And when I went for*	tsopano anandiuza kuti inunso
1155.		*examination to find out the*	ndiofunika mupote akakuyeze-
1156.		*real problem of my not giving*	ni kuti tione kuti vuto lanu
1157.		*birth but the doctor sent me*	likulepheretsa kubereka ndi
1158.		*away, saying saying go, go go,*	chiani ndiye kupita kuja
1159.		*you are old don't come back.*	adokotala ali iyayi tiyeni
1160.		*Then we just returned home.*	pitani mwakalamba
1161.		*When we came back that is*	musabwerere pitani basi
1162.		*when we decided to go to the*	tinangobwerako, kubwera
1163.		*private hospital and we had to*	kuno tiri iayi kuli bwino tipeze
1164.		*find money, when we got them*	ndalama tipite chipatala
1165.		*then there was another*	cholipira ndi mmene ndalama
1166.		*problem came in and we used*	tinazipeza kugwanso vuto lina
1167.		*that money but we intended to*	ndalama zija tinaononga koma
1168.		*go to the private hospital*	tinafuna kuti tipite mwenzi
1169.		*within the next month.*	wa mawa.
1170.	T Hmhm she's saying that		
1171.	they went to the		
1172.	traditional healers and		
1173.	they gave some		
1174.	medicine, and when		
1175.	they nothing happened.		
1176.	And they went to the		
1177.	hospital and the doctor		
1178.	told them that to, he she		
1179.	told		
((end of tape, part missing))			
1181.	I And they should		
1182.	collect sperm		
1183.	T yah, yah, so when they		
1184.	went to the hospital		
1185.	they they they checked		
1186.	the sperm at government		
1187.	hospital.		
1188.	I Hmhm		
1189.	T So, they chased him [her]		
1190.	away, saying that ah		
1191.	you're old, you can't		
1192.	even manage to have		
1193.	a kid.		
1194.	I The husband, or; they		
1195.	they they chased the		
1196.	husband away?		
1197.	T Yeah, both of them, so		
1198.	they wanted to go to a		
1199.	private hospital, so that		
1200.	they can help them.		
1201.	I Oho, oh.		

Extract 6:4. Int 14. Inf.w

106.	I Okay. How would you		
107.	describe your		
108.	relationship with your		
109.	husband?		
110.	T	*How would you describe your*	Mungalongosole bwanji ulongo
111.		*relationship with your*	wa pakati pa inu ndi amuna
112.		*husband?*	anu?

113.R		*Uh, since we, uh since we have*	Ndiye nanga si nanga si iwo
114.		*been trying long enough we*	nde zimayesesa. Kenaka aa basi
115.		*then decided to give up because*	( ) malingana ndi kutopa
116.		*( ) we were tired of*	ati aa (basi tingokhala
117.		*trying.*	tiwiriwiri) tingopuma basi.
118. T	She's saying that they		
119.	have tried their best to		
120.	solve the problem,		
121.	but just because		
122.	nothing has been		
123.	happening so, they		
124.	just decided just to		
125.	settle down.		
126. I	Hm:. Okay, aha.		
127.	And if you say that		
128.	you just decided to		
129.	settle down in which		
130.	way?		
131.T		*Now that you have said that*	Pamene mwanena zoti basi
132.		*after having tried for so long,*	tinangoganiza kuti
133.		*you decided to give up. What do*	mutayendayenda, kuyesayesa
134.		*you mean by 'we decided to*	basi munangoganiza kuti
135.		*give up'? Hhuhu.*	tingokhala, mukutanthauza
136.			chiyani? Hhuhu.
137.		*hhuhu, since eh, since uh, it*	Hhuhu, Nanga si kuti, ah,
138.		*means, it means that after I had*	ndikutanthauza kuti nanga
139.		*failed, we had failed, taking*	sikuti malinga ndikupanga
140.		*medicine but did not help,*	ndikulephera ndine ( )
141.		*taking medicine but did not*	kunalephera ifezo … ndiye eya
142.		*help, then we decided to stop*	kudya mankhwala osathaniza,
143.		*and do nothing.*	eya kudya mankhwala
144.			osathandiza ( ) ndiye basi
145. T	She is saying that aa		kumangokhala.
146.	taking medicine for		
147.	quite a long time, since		
148.	the problem is not		
149.	solved they just		
150.	decided to give up		

A first feature of the respondents' descriptions which I would like to note is that, both respondents in extracts 3 and 4 make clear that they were taking action, but stopped at some point. Hence, as in extract 2, the respondents' references to inaction are embedded in descriptions of previous action. In extract 3, the respondent refers to her actions when she states that she was 'taking the medicine' (line 1142-1143), that she and her husband went 'to the government hospital' (lines 1148, 1151-1152), where they examined her husband's sperms only, after which the respondent herself 'went for examination' (line 1154-1155). The interpreter refers to the respondent's actions when she says 'they went to the traditional healers' (line 1171-1172), 'and they went to the hospital' (line 1176-1177). The respondent implies that she stopped

taking action when she points out that the doctor in the government hospital sent her away (line 1157-1158), upon which she and her husband went home (line 1160), and that after they got money to go to a private hospital, they had to use it when 'another problem came in' (lines 1165-1167). In extract 4, the respondent points out she was taking action by stating 'we have been trying long enough' (line 114) and 'taking medicine' (lines 139-141). She makes clear that she stopped her actions when she states: 'we then decided to give up because we were tired of trying' (lines 115-116), and 'we decided to stop and do nothing' (line 142-143).

A second feature worth noting is that the respondents in extracts 2 and 3 make their claims that they have taken action convincing. The respondents provide details about their previous actions, specifically about where they went for help ('Banja LaMtsogolo' in extract 2, the government hospital in extract 3), and what was examined ('they examined my husband's sperms only', extract 3, line 1153). As Potter and Edwards (1992) have pointed out, providing details can be a way to work up the factuality of one's claims. In addition, the respondent in extract 3 uses reported speech in her description of what the doctor said to her: 'the doctor sent me away saying 'go, go go you are old, don't come back' ' (lines 1157-1159). As Wooffitt (1992) and Hutchby and Wooffitt (1998) have argued, reported speech also fulfills a rhetorical function of making claims factual.

By making clear that they have taken action in the past, the respondents make clear that they tried to seek for a solution. They do this in other ways as well. In extract 4, the respondent states explicitly that 'we have been trying' (line 113-114) and 'we were tired of trying' (line 116-117). The interpreter attends to the respondent's attempts in lines 118 to 119: 'they tried their best to solve the problem', and in line 132: 'after having tried'. In addition, in extracts 2 and 4, the respondents and interpreter speak about 'failure'. In extract 2, the respondent states that they 'failed to get money', because of which they stopped (line 412). The interpreter subsequently points out that he 'failed to continue' (line 416). In extract 4, the respondent states 'after I had failed, we had failed' (line 138-139). By saying 'failed' to get money or continue, instead of for instance 'did not' (get money/continue), the respondent and interpreter imply that the respondents *tried* to get money and take

action, although they did not succeed. For, one cannot 'fail' in something, without having made an attempt.

Noteworthy is that in extract 4, the respondent characterizes her attempts as enduring by saying 'long enough' (lines 114), and 'we were tired of trying' (line 116-117), which makes available the inference that the attempts were long enough to get tired. The repetition of 'taking medicine' in lines 139 to 142 also makes clear that the respondent's attempts went on for a while. By constructing her attempts as (sufficiently) enduring, the respondent attends to and forestalls assumptions that she has not tried enough. The interpreter picks up on this performative function of the respondent's references to her enduring trying, when she states that the respondent and husband tried 'their best' (line 119). Thereby she makes explicit that the respondent and her husband tried as much as they could, and thus that they tried enough.

The respondents offer their (enduring) attempts as an explanation, or account, for the discontinuation of action by preceding it with 'since' and 'because': 'since we failed (….) we just stopped, (extract 2, lines 412-413), '*since* we have been trying long enough' we gave up (extract 4, line 113-114), and '*because* we were tired of trying' (extract 4, line 115-117). Hence, the respondents use their references to their attempts to make their discontinuation understandable and thus (more) justified.

As said before, respondents attend to claiming not to take action as a dispreferred breach of expectations. By claiming to have taken action in the past, and (thus) to have tried taking action, the respondents can be seen to mitigate any culpability for not taking action anymore. This in part because references to their previous actions and attempts forestall the assumption that respondents' are not motivated to take action. In extract 3, the respondent makes relevant her motivation, when she makes explicit her intention to go to the private hospital: 'we (had) intended to go to the private hospital' (lines 1145 to 1147 and line 1167-1168). In addition, the claim 'we decided to go to the private hospital' (1162) conveys a commitment, and thus intention, to take action. Hence, the respondent provides several references to her intention and decision to go to the hospital, and thereby emphasizes her motivation to take action. Moreover, the respondent's intention is constructed as firm and factual by details regarding the time span within which the

action would be taken, namely 'within the next month' (line 1169), and to the specific moment at which the decision was made: 'when we came back, that is when we decided' (line 1161-1162). Note that the interpreter too, makes relevant the respondents' intention and motivation to take action when she states 'so they wanted to go to a private hospital' (lines 1197-1199).

In the next section, I will examine in more detail how respondents explain their inaction, and how these explanations play a role in mitigating respondents' culpability.

6.2.2 Explaining inaction: Identifying external obstacles

In all the extracts which I have shown so far, respondents account for and explain their inaction or discontinuation of action. I have mentioned that the respondents in extracts 1 and 2 explain that they do not take action (anymore) due to lack of money. Also in extract 3, the respondent explains that she points out that she could not go to the private hospital because 'we used that money' (line 1166-1167). Note that the interpreter in extract 2, emphasizes that lack of money was why the respondent stopped taking action, by referring three times to it: 'because of shortage of money' (line 418), 'if they could have money' (line 425), and 'they don't have money to pay for the Banja La Mtsogolo' (line 430-431).

In extract 3, the respondent identifies another reason for her discontinuation of action. She states that 'the government hospital did not give me much attention' (line 1148-1149), explains that people in the hospital examined 'only' her husband's sperms (lines 1152-1153), and that 'the doctor sent me away' (line 1157-1158). Hence, the respondent attributes her discontinuation of action to others, namely people at the hospital and specifically the doctor whom she consulted.

By means of these explanations, respondents make their inaction understandable and hence more justified. The explanations appear to fulfil this justificatory function especially because they identify practical obstacles to taking action, which are unrelated or 'external' to respondents' motivation to take action. By identifying money or the doctors' dismissal as a reason for not taking action (anymore), respondents can be seen to imply that they would take action, if they would have money, or if the doctor would not have sent them away. The interpreter

in extract 2 makes this implication explicit by using an 'if-then' construction (Edwards & Potter, 1992): 'if they could have money' (then) 'they could have continued to take medical (.) drugs' (lines 425 to 426). Thereby he suggests that money is a condition for taking action, that is he suggests that the respondent would have taken drugs, if only he had had the money for it.

Thus, like making clear to have tried to take action, identifying reasons for inaction which are external to oneself portrays inaction as not due to a lack of motivation, and thereby plays down respondents' culpability for it. There appears to be a second way in which identifying external obstacles enables respondents to play down their culpability, which can be observed in extract 5, displayed below.

Extract 6:5 Int. 44 inf.w

407.	R	But to people say that 'just try to traditional drugs that' so I answer them that ah, my
408.		husband is refusing. He is a medical assistant, he is a doctor, so he can't (2) he
409.		can't (2) hhu she is refusing that you can't you you drunk, ujeni [what]
410.		traditional drug is not eh good.
411.	I	uhu
412.	R	Just stay without anything, God will provide.
413.	I	Okay. That's what your husband was saying.
414.	R	Yah.
415.	I	But how, you yourself, how did you think about [traditional
416.	R	[hhu
417.	I	medicines?
418.	R	Ah, I just stay that, ah if my husband is refusing, so: what can I do.
419.	I	uhu
420.	R	yah. I am: in your hands, so, I don't have any power.
421.	I	You couldn't take medicines if your husband didn't want you to take
422.		[them.
423.	R	[Yes.
424.	I	Uhu
425.	R	Hm. I just stay, no any drugs.

In extract 5, the respondent makes clear that she does not take action to solve her fertility problem when she states 'just stay, no any drugs' (line 425). She provides an explanation for her inaction: 'ah, my husband is refusing.'(lines 408-409, see also 410 and 424). Hence, like the respondent in extract 3, she identifies someone else as obstacle to seeking a solution, namely her husband. The respondent accounts for her husband's refusal by making relevant the membership categories 'medical assistant' and 'doctor'(lines 409), and by making clear that taking traditional medicine is at odds with the normatively expected, category bound activities (Sacks, 1992) of biomedical personnel. She does this by stating 'he is a medical assistant, he is a

doctor, so he can't (2) he can't (2)' (line 408-409) and 'traditional drug is not eh good' (line 410). This account makes the respondent's claim that her husband refuses to let her take traditional drugs understandable, and thereby it makes its factuality more convincing. Note that by stating that when people advise her to try traditional drugs, '*I answer them* that ah, my husband is refusing' (line 407-408), the respondent explicitly attends to not taking action as in need of an 'answer' and thus as accountable.

By referring to her husband's refusal as reason for not taking medicine, the respondent portrays her inaction as outwith her own control. She attends to her lack of control when she states 'so: what can I do' (line 418). This question is made into a rhetorical question because it is treated as not requiring an answer. The interviewer produces after the question only a continuer 'uhu' (line 419), rather than an answer. Nevertheless, the respondent subsequently continues in a next turn (line 420). Because of its rhetorical nature, the question 'what can I do?' makes the point that there is nothing that the respondent can do, considering her husband's refusal. Hence, the respondent constructs herself as powerless. She does this as well by explicitly stating 'I don't have any power.' (line 420) and 'I am in your hands' (line 420). The respondent emphasizes her lack of power by means of the extreme case formulation (ECF) '[not] any power' in line 420. In addition, the expression 'I am in your hands' (line 420) evokes a relatively extreme image of someone whose actions are controlled by someone else.

By making clear that their inaction is outwith their own control by identifying reasons for their inaction external to themselves, respondents play down their responsibility and thus culpability for not taking action. Identifying others as obstacles enables respondents to can play down their culpability in a third way. This can be observed in extract 3, and extract 6, displayed below. For ease of reference, the relevant parts of extracts 3 are displayed once more below.

Extract 6:3 Int. 12 inf.w

1154. R 1155. 1156. 1157. 1158. 1159. 1160.	*And when I went for examination to find out the real problem of my not giving birth but the doctor sent me away, saying saying go, you are old, don't come back, go, that's it.*	ndikuyeza tsopano anandiuza kuti inunso ndiofunika mupote akakuyezeni kuti tione kuti vuto lanu likulepheretsa kubereka ndi chiani ndiye kupita kuja adokota -la ali iyayi tiyeni pitani mwaka-lamba musabwerere pitani basi
((some lines omitted)) 1189. T So, they chased him 1190. [her] away, saying that 1191. ah you're old, you can't 1192. even manage to have a 1193. kid.		

Extract 6:6 Int. 53 inf.w ((respondent has been talking about her problem of irregular menstruation problems))

196.R 197. 198. 199. 200. 201. 202. 203. 204.	*At the Hospital they told me to bring (.) I really tried, so that there is even a book there at the hospital. After giving me the book, they told me to bring my husband, I told my husband, he refused. I told him, he refused! Ah (.) ah (.)me, to the hospital, I we[:nt.*	Nditapita ku chipatala kuja adandiwuza kuti mukabwere.(.) ine ndidayesetsa ndithu, moti buku liliko kuchipatalako. Adandipatsa ndithu kuti mukabwere ndi banja lanu, kuwawuza banja lathuli kukana. Kuwawuza kukana! Ah. (.) ah (.) ine ku chipatala, ndinapi[taa.
205. T	*[oho:*	[oho:
206.T =so he [she] went to 207. the hospital to 208. explain 209.I H:mhm 210.T And they asked her 211. to br- to take- to go 212. with the husband. 213.I Yah. 214.T So when she came 215. back she told the 216. husband, the 217. husband didn't take 218. it seriously. 219.I Hmhm. 220.T She told she never 221. went back to the 222. hospital. 223.I O:[kay		

224.R		*Upon telling him, he has*	Kuwawuza kuti tipite kukana.
225.		*refused to go. That time there*	Nthawi ija kunali a Banda kuti
226.		*was Mr.Banda*[37]*, he refused to*	tipite ku chipatala, ai ndithu
227.		*go to the Hospital, this husband*	abambowa kumakana kuti
228.		*refusing to go for a test for them*	akatiyese akawone chikuchitika
229.		*to see what is happening in our*	ndi chiyani m'nthupimu.
230.		*bodies. Sometimes, I have sharp*	Mwina pena pake ine
231.		*pains in my stomach, sharp*	m'mimbamu mmandipota,
232.		*pain, the strength of*	kupota, mphamvu yofuna
233.		*what? Wanting to give birth. So*	kutani? Kubereka. Ndiye
234.		*I do not know what is*	sindidziwa kuti chimatika
235.		*happening.*	ndichiyani.
236. T	So until now, he has		
237.	not accepted to go to		
238.	the hospital [to see the		
239.I	[hmhm		
240.T	doctor, so it happens		
241.	that sometimes she has		
242.	abdominal pain		
243.	intensively,		
244. I	Hmhm		
245.T	Eh but ehhh it		
246.	continues ( )		

As said before, the respondent in extract 3 points out that a doctor in the government hospital sent her away. In extract 6, the respondent makes clear that her husband prevents her from further pursuit of a solution when she points out that she was told at the hospital to bring her husband, but that he refused to go (lines 202, 225,226, 228). In lines 228 to 230, the respondent identifies more specifically what her husband refuses: 'to go for a test for them to see what is happening in our bodies' , so she does not know 'what is happening' (line 232-234). The respondent implies that her husband's refusal prevents doctors from diagnosing their problem, and thus by implication, taking action to solve it.

Both respondents describe the other's (respectively the doctor's and husband's) behaviour in such a way that it is portrayed as blameworthy. As mentioned before, the respondent in extract 3 uses reported speech (Hutchby & Wooffitt, 1998) when she describes the doctors' reaction: 'the doctor sent me away, saying go, you are old, don't come back, go' (line 1157-1160). Drew (1998) has noted that reported speech is commonly used in complaints, which pertain to what someone said. In addition, he points out that design features of the reported speech tend to provide for the blameworthy character of the reported conduct (op cit.). In

[37] Name has been replaced by pseudonym

line 1159, the respondent repeats the short imperative 'go', in addition to using the command 'don't come back'. Widdicombe and Wooffitt's (1995, p. 122) note about a similar command, namely 'get out', that it 'formulates in the harshest possible terms what could otherwise be described as a request to leave'. Similarly, 'go, you are old, don't come back, go' (line 1159-1160) portrays the doctor's 'request to leave' as harsh and dismissive. The interpreter picks up on the dismissive, harsh quality of the doctors' behaviour, when she states 'they chased him [her] away' (line 1189-1190). 'Chasing away' has negative, callous connotations. By constructing the doctors' behaviour as harsh and dismissive, the respondent makes it blameworthy.

In extract 6, the respondent constructs her husband's behaviour as blameworthy by making clear that not being able to know 'what is happening' is problematic. She does this by pointing out the seriousness of the fertility problems she is suffering, when she refers to the 'sharp pains in my stomach, sharp pain' (lines 230-232), made relevant in the interpreter's translation as well: 'sometimes she has abdominal pain intensively' (lines 241-243). In addition, the respondent relates these pains to 'the strength' of 'wanting to give birth' (lines 232-233). Thereby she makes clear that she has a strong desire to give birth, considering that it has a physical correlate, namely the sharp pains. By thus bringing out the seriousness of her fertility problem, the respondent points to the need to solve it, and provides for the husband's refusal to be seen as problematic and blameworthy.

In both extracts, the respondents make respectively the doctors' and their husbands' behaviour particularly complainable and blameworthy by making relevant their membership categories. In extract 3, the respondent states explicitly that 'the *doctor* sent me away, saying' (line 1157-1158). As Sacks (1992) has pointed out, membership categories are associated with certain category bound activities (CBAs). One such category bound activity of doctors is assisting patients; they are expected, and seen as having, a duty to help patients (cf. Parsons, 1951). As sending and certainly 'chasing' patients away is at odds with this duty, it is recognizably complainable and culpable. In extract 6, the respondent explicitly states that 'this husband' (line 227) refuses to go for a test. This makes relevant membership attributes of the category 'husband', such as being in partnership with, and supportive of one's wife. Her husband's refusal to go to the hospital is observably

not in line with these membership attributes, bringing out its inappropriateness and culpability.

By constructing others', rather than their own behaviour as blameworthy, respondents can be seen to direct blame for not taking action away from themselves to the others' who are obstructing them. The respondent in extract 6 accomplishes this diverting of blame as well by establishing a contrast (cf. Widdicombe & Wooffitt, 1995) between her own and her husband's behaviour, in particular, between her own effort to seek a solution and her husband's inaction, that is, his refusal to go to the hospital. The respondent makes clear that 'I really tried' (line 197) and 'me to the hospital, I went' (line 202-203), whereas, as mentioned before, she refers several times to her husband's refusal to go to the hospital. The respondent brings out the contrast in their behaviour by stating that she herself went to the hospital (line 202-203) directly after she has mentioned 'he refused' (line 202). By using the pronoun 'me', in addition to 'I', the respondent underlines the difference between her own, and her husband's actions. Thus, the respondent portrays her husband's, *unlike* her own behaviour, as blameworthy, thereby diverting blame away form herself to her husband.

I would like to note that respondents who identify others as obstacles do not necessarily blame them for it. For instance, I have shown how in extract 5 the respondent constructs her husband's refusal and prevention of her taking medicine as understandable. She does this by attending to common sense understandings that not using traditional medicine is a membership category attribute of medical practitioners (line 408). In so doing , she constructs her husband's refusal as reasonable, justifiable and thus not blameworthy.

It appears then, that by constructing their inaction as being due to reasons external to themselves, respondents can play down their culpability in various ways: by forestalling the inference that they are not motivated to seek for solutions, playing down their responsibility for their inaction, and diverting blame away from themselves to others who obstruct their actions.

6.3 Inaction as deliberate, reasonable decision

However, respondents do not always construct their inaction as due to external obstacles; as the extracts below show, respondents can also attend to their inaction as deliberately chosen. Note that extract 7, has largely been displayed before as extract 4.

Extract 6:7 Int. 14 inf.w

106.I	Okay. How would you describe your relationship with your husband?		
110.T		*How would you describe your relationship with your husband?*	Mungalongosole bwanji ulongowa pakati pa inu ndi amuna anu?
113.R		*Uh, since we, uh since we have been trying long enough we then decided to give up because ( ) we were tired of trying.*	Ndiye nanga si nanga si iwo nde zimayesesa. Kenaka aa basi ( ) malingana ndi kutopa ati aa (basi tingokhala tiwiriwiri) tingopuma basi.
118 T	She's saying that they have tried their best to solve the problem, but just because nothing has been happening so, they just decided just to settle down.		
126. I	Mmm. Okay, aha. And if you say that you just decided to settle down in which way?		
131.T		*Now that you have said that after having tried for so long, you decided to give up. What do you mean by 'we decided to give up'? Hhuhu.*	Pamene mwanena zoti basi tinangoganiza kuti mutayendayenda, kuyesayesa basi munangoganiza kuti tingokhala, mukutanthauza chiyani? Hhuhu.
137.		*hhuhu, since eh, since uh, it means, it means that after I had failed, we had failed, taking medicine but did not help, taking medicine but did not help, then we decided to stop and do nothing.*	Hhuhu, Nanga si kuti, ah, ndikutanthauza kuti nanga sikuti malinga ndikupanga ndikulephera ndine ( ) kunalephera ifezo … ndiye eya kudya mankhwala osathaniza, eya kudya mankhwala osathandiza ( ) ndiye basi kumangokhala.
146.T	She is saying that aa taking medicine for quite a long time, but since the problem is		

150. not solved they just
151. decided to give up.
152.I Okay, mmhm so do
153. you mean that you
154. are not really seeking
155. for solutions anymore
156. right now?

157.T 158. 159. 160.	*So now you mean that you are not going to continue the struggle and that you are going to stop?*	Panopa ndiye kuti mukutanthauza kuti basinso simu simulimbananazo mungozisiya?
161.R 162. 163. 164.	*Hhuhu it is still possible, it is wanted, it is still wanted that maybe you could then have it a child yes.*	Hhuhu zimapangabe zimafu nika, zimafunikabe kuti mwina ukakhale naye mwana ee.

165.T She saying that
166. there is a possibility that
167. they want to have the
168. kid, but because things
169. are not working they
170. just leaving it like that.

Extract 6:8 Int.27 inf.w ((The respondent mentioned before that she had several miscarriages, the last one of which was an ectopic pregnancy.))

184. I Hm. ◦Okay◦ (3) Ehm, and when you spoke to the doctors at the hospital did they tell you
185. anything or explain you anything or? Advise you anything?
186. R. Yes. They just called us together with my husband and they were saying that if we want
187. another child it's it's possible. But the way I was, we just decided that maybe, I can just
188. stay.
189. I uhu
190. R Because we are thinking (back/that), maybe it will happen again.
191. I Okay, yah
192. R Because when I was there in hospital,
193. I hm
194. R I think the same day one had a very like problem with me, and he died there at the
195. theatre.
196. I uhu
197. T Maybe the: the fallopian tube bursted before the operation.
198. I uhu
199. T because once it burst
200. I okay
201. T there is no help.
202. I You said you s- there was someone with a similar problem like you.
203. R Yes, yes.
204. I Okay. So was it then that you actually decided with your husband that you would stop
205. trying to have more children?
206. R Yes. Because we were just thought that no, at least one which is enough,
207. I Hm
208. R rather than maybe one can just to die.
209. I Yeah, yeah. Yah, I can imagine that you made that decision at that point. Uhu. Did you
210. find it difficult to decide that like no, we'll give up trying to have more children?
211. R No.
212. I Hm
213. T After all the pains, it won't be difficult.
214. I Hm, yeah Yeah. Because I guess you both thought that your life was really more
215. [important.
216. R [Yes, yeah

In extract 7 the respondent indicates that she is not taking action when she states ‘we then decided to give up’ (lines 114-115) and ‘then we decided to stop and do nothing’ (lines 142-143). In extract 8, it can be inferred that the respondent is not taking action anymore in order to have another baby when she explains that ‘we just decided that maybe, I can just stay’ (line 187-188).

As in all other extracts seen so far, the respondents account for their inaction. However, the accounts differ from the ones discussed before. This first of all because the respondents portray their inaction as deliberately choosen for. They explicitly refer to their decision: ‘we then decided to give up’ (extract 7, line 115), ‘then we decided to stop and do nothing’ (extract 7, line 142-143) and ‘we just decided that maybe, I can just stay’ (extract 8, line 187-188).

Making one’s inaction into something chosen for appears to be at odds with respondent’s orientation to inaction as a problematic breach from expectations that one takes action. However, the respondents construct their decisions not to take action anymore as understandable, and thereby arguably as justifiable. The respondent in extract 7 does this by making relevant the ineffectiveness of the actions she took: ‘taking medicine but did not help’ (lines 139-142). The interpreter attends to the ineffectiveness of the respondent’s actions as reason for her decision to stop taking action when she states: ‘just because nothing has been happening, so, they just decided just to settle down’ (line 121-125) and ‘but because things are not working they just leaving it like that’ (lines 162-164). The extreme case formulation ‘nothing’ (line 122) emphasizes the medication’s ineffectiveness, making it into a stronger argument for the respondent’s discontinuation of taking the medicines.

Note that the respondent’s claim regarding the ineffectiveness is sustained by her aforementioned references to previous, enduring attempts to seek a solution. These references make her claim regarding the medicine’s ineffectiveness based on long term empirical observations, rather than on a priori belief. As a result, the respondent makes her decision to discontinue more warranted.

In extract 8, the respondent makes her decision reasonable by making relevant the health risks involved. Before the extract, the respondent has made clear that she has had several miscarriages, of which the last one was an ectopic

pregnancy. The respondent makes relevant its serious, potentially lethal health risks when she describes how someone who 'had a very like problem with me' , 'died there at the theatre' (lines 194-195) and states that 'we were just thought that no, at least one is enough, rather than maybe one can just to die' (lines 206-208). Moreover, the respondent here makes explicit that her and her husband's decision to not pursue a pregnancy is dependent on their awareness of these risks. Both respondent and interpreter stress the reality of the health risks involved. By pointing out that the other patient died 'there at the theatre' (line 194), the respondent makes clear that even when immediate medical interventions are available, an ectopic pregnancy can result in death. Similarly, the interpreter stresses the viability of the risks of ectopic pregnancy, when she points out that 'once it burst' there is no help (line 201). In addition, the interpreter proposes a mechanism for how ectopic pregnancy may lead to death: 'maybe: the fallopian tube bursted before the operation' (line 197). Thereby she brings out the potential of ectopic pregnancies to be a deadly, and thus serious, health threat.

By making relevant serious potential health risks as warrant for the respondent's and her husband's decision to 'just stay', this decision is made understandable, reasonable and thus justified. Both the interviewer and interpreter attend to the account provided as acceptable. The interviewer does this in line 209 when she states 'I can imagine that you made that decision at that point'. In lines 209 to 210, the interviewer asks whether the respondent found it difficult to decide to give up trying to have children. After the respondent provides a minimal, negative response of 'no' (line 211), the interpreter provides an additional account: 'after all the pains, it won't be difficult' (line 213). By thus constructing the decision as something which 'won't be difficult', the interpreter attends to it as logical, understandable and thus acceptable.

Thus, the respondents of extract 7 and 8 construct their discontinuation of action as their own, deliberate but reasonable decision, and thereby appear to mitigate their culpability for not adhering to the normative course of action. Nevertheless, it appears that this construction of in-action can evoke certain problematic interactional issues. When respondents identify external obstacles as reason for not taking action, they leave open the option that they will continue to

seek for solutions, once the obstacles are removed. However, the construction that one has wilfully chosen not to take action (anymore), makes available the inference that one has permanently stopped trying to solve one's fertility problem. In extract 7, the interpreter shows that she infers this when she translates the interviewer's gist (line 141-150) as 'so now you mean that you are not going to continue the struggle and that you are going to stop?' (lines 151-154). Heritage and Watson (1978) have pointed out that gists select and propose the main meaning of a preceding account. The interpreter's gist selects the respondent's permanent decision to not continue 'the struggle' as the 'essence' of the respondent's account. This appears to make available problematic inferences. Although confirmations are the interactionally preferred response to gists, 'fixing' the proposed meaning of the previous exchange (Heritage & Watson, 1978), the respondent does not provide a confirmation in response to the gist. Instead, she avows the possibility of, and desire for, having a child: 'it is still possible, it is wanted, it is still wanted that maybe you could then have it, a child yes' (lines 155-158). Thereby she can be seen to attend to and forestall the inference that she and her husband do not want to have a child anymore. Hence, it appears that being seen as having permanently given up to take action in order to solve a fertility problem, can make available the inference that one does not want to bear children anymore. Considering the respondent's avowal of her child-wish, this inference is treated as undesirable.

6.4 Summary and Discussion

In this chapter, I have shown how respondents treat not taking action as an accountable issue and problematic deviation from the normatively expected and preferred course of action. When accounting for their inaction, respondents appear to mitigate their culpability, in several ways. First of all, respondents point out that they have tried to take action and attribute their inaction to external obstacles which are difficult to control, like money or other people. Thereby they suggest that their inaction is not due to a lack of motivation. Second, by identifying external obstacles as reason for their inaction, respondents can play down their responsibility and thereby mitigate their culpability. Third, I have shown how respondents use their

attribution of inaction to others to divert blame away from themselves to these obstructing others. Fourth, some respondents construct their inaction as reasonable decision, based on pragmatic reasons, thereby making it justifiable. Nevertheless, this construction can lead to problematic inferences that one does not want to bear children. I have shown how this inference can be treated as problematic, something one would expect considering respondents' constructions of childbearing as normatively required (see chapter 4).

Several of the analytic points made in this chapter are in keeping with work by other scholars. In chapter 4, I discussed Parsons's (1951) notion of the sick role, and how this denotes a set of obligations which ill people ought to adhere to. According to Parsons, people ought to consider their illness as undesirable, to be motivated to get better and seek competent technical help in order to achieve this. Respondents can be seen to attend to these obligations by treating inaction as problematic, by showing to have tried to seek competent help and to be motivated to solve their fertility problem. Hence, there are commonalities between my analytic observations, Parsons' (1951) work and others who have shown how people with various health problems attend to obligations of the 'sick role' (Guise, 2005; Parry, 2004, see chapter 4). As mentioned as well in chapter 4, this suggests that Parsons' (1951) notion of the sick role pertains to a set of common sense rights and obligations regarding ill people, widely available for use by people in various contexts.

Second, the observation that respondents construct inaction as due to external factors which are relatively difficult to control, and my claim that in so doing, they mitigate their responsibility and thus culpability, fits in with work by McHugh (1975) and Taylor (1972). McHugh argues that 'deviance' is a negotiable judgement (see also Jeffery, 1979), which depends on the absence of 'conditions of failure', which are situations which justify the occurrence of certain abnormal behaviour. According to McHugh (1975), one of these justifying conditions is that an alternative way of acting is seen as impossible (cf. Jeffery, 1979). Taylor (1972)'s study of motives for sexual offences that 'external' explanations lends empirical support to this claim. He found that accounts according to which the offender had no control over his or her behaviour and thus could not choose to act differently, were judged

by magistrates to be more likely and acceptable. In my study, respondents can be seen to play down their culpability by drawing upon a 'condition of failure'. By identifying external obstacles as reason for their inaction, respondents make clear that an alternative way of acting, that is taking action, was highly problematic, if not impossible for them.

As mentioned in this chapter's introduction, some authors (Sundby et al. , 1998; Unisa, 1999) report reasons mentioned by research participants for not seeking help for their fertility problem, such as 'no money' (Sundby et al., 1998; Unisa, 1999) and 'husband's unwillingness to seek help' (Sundby et al., 1998). These reasons are strikingly similar to the ones provided by the respondents in the data discussed in this chapter. By examining how respondents use these explanations, I have shown how they can be seen as accounts which deal with certain interpersonal, normative and moral issues. Respondents appear to take into account others' normative judgements of their inaction by treating it as dispreffered, and accounting for it, and in so doing they deal with issues of blame, that is, they mitigate their culpability for not taking action. This suggests that treating reasons for taking action or not taking action as individual cognitions, which are variables in individuals' cost-benefit analyses and determinants of people's behaviour is problematic. Researchers, policymakers and practitioners alike should bear in mind that when they ask people why they take or do not take certain actions or lack of actions, the reasons provided will be tailored, at least to some extent, to a specific social and interactional context and the issues it raises.

Hence, the analysis presented in this chapter has theoretical and methodological implications, which I will discuss in more detail in chapter 10. Furthermore, insights obtained into people's accounts and constructions of their (in)action, and the issues they thereby attend to may be transferable to their actions outside the interview context. For instance, orientations to inaction as problematic breach of expectations may inform people's relentless search for solutions, which is frequently reported in the literature. Hence, the analysis presented in this chapter may have practical implications. However, the transferability of findings and the possibility to use them as a basis for practical interventions is a complicated issue, which I will address in detail in chapter 10.

Up to this point, the chapters of this thesis show that infertility and its management is permeated with interpersonal, normative and moral issues. Considering that these are fundamentally 'relational' issues, exploring constructions of relationships between people with a fertility problem and others appears relevant. I will do this in the next chapter.

Chapter 7. 'Not blaming' in constructions of (troubled) relationships

Most studies of infertility in developing countries stress the many social consequences of infertility and how it affects relationships at a conjugal, family and community level. Hence Neff's (1994, p. 477) characterisation of infertility as a 'disease of social relations'. However, a closer look at findings reported in qualitative studies of infertility in developing countries reveals a certain ambiguity. Some authors find that, at least at times, respondents report that marital, family or community relationships are not affected (Dyer et al., 2004; Meera Guntupalli, 2002; Unisa, 1999), or that marital relationships even improve (Dyer *et al.*, 2002; Gerrits et al, 1999; Inhorn, 2003; Pashigian, 2000). In addition, as pointed out in the literature review, authors tend to report women's *worries* about abandonment by their husbands (Gerrits, 1997; Papreen et al, 2000; Sundby, Mboge & Sonko, 1998; Sundby, 1997; Dyer et al., 2002), but research participants' reports of actual divorce and abandonment are more rare, and are at least in some instances based on what community members say, rather than on accounts from people with a fertility problem themselves (Papreen et al, 2000).

The ambiguity and variability in people's descriptions of relationships between people with fertility problems and others calls for further, detailed investigation. Hence, in this chapter, I will examine responses to questions about changes in relationships. In the preliminary analysis, I was struck by two observations. First, various respondents portrayed their relationships, with their spouse or others, as good. This was surprising considering the emphasis in the literature on the abandonment, stigmatisation, and exclusion of people with a fertility problem. Second, when respondents did describe relationship troubles, these came across as very neutral. This even though the content of the accounts, such as reports of husbands' extramarital affairs or parents telling a respondent to 'go away', seemed to make complaints and blamings expected and justified activities.

Hence, I decided to look in more detail at accounts of relationships and in particular relationship troubles. In this chapter, I will discuss how respondents construct relationships as good, play down the significance of relationship troubles, do not complain about others' behaviour and construct them as not to blame for it.

Close attention to respondents' descriptions *and* the questions they are asked, brings out certain interpersonal, moral issues which respondents are dealing with when describing their relationships. In the discussion, I will address discrepancies between my findings and the literature, and discuss how my findings bring out the need to examine what people say about their relationships in detail.

7. 1 Constructing relationships as good

I will start with an examination of how men and women with a fertility problem construct their own marital relationships, in response to the question whether anything has changed in their relationship with their spouse.

Extract 7:1 Int. 47 infw/m

642. I I was wondering since you were thinking about this issue like oh we really
643. would like to have children, em, did anything change in any way in the
644. relationship between you two?
645. Rm A:h no, it's the usual situation,
646. I Uhu
647. Rm Yah. the usual. No any change, no any transformation of any kind.
648. I Okay
649. R Yes. No any shaken.
650. I Uhu
651. Rm We are just discussing friendly, politely, that doesn't do this doesn't do this
652. now, let us go ( )
653. I yah
654. Rm Uhuhu.
655. I Okay

Extract 7:2 Int.24 inf.m

173.I Hmhm, okay, when
174. you were noticing that
175. no children no more
176. children came, did that
177. change anything in the
178. relationship between
179. you and your wife?

180.T	*She says, when you noticed*	Akuti, pawayiweni kuti kutandila
181.	*that between '79 and '87*	ndawi jele '79 mpaka '87,
182.	*there are no more children*	pachilikati papamwangali soni
183.	*coming, was there a change*	mwanache mnyumbamo ana
184.	*in the relationship between*	ndawi jelejo pali chine chili
185.	*you and your wife or not?*	chose chakuti kapena
186.		chinonyelano pajati pakwele ni
187.		alamu chanandipe kapena iyai?

188.R		*No, our love for one another is*	iayi, chinonyelano chachiwela
189.		*still the same up to this*	mpaka pakali pano.
190.		*moment*	
191.T	Ah he says there's		
192.	no change up to		
193.	this time.		
194.I	Okay.		
195.T	Yah, loving and		
196.	another.		
197.I	Okay.		
198.T	Since they know that		
199.	time has come.		
200.I	Hmhm. Okay		
201.T	So there's no need to		
202.	disturb about their		
203.	love.		

Extract 7:3 Int.39 inf.m

285. I Ehm I was wondering since you noticed if you have this problem with, of
286. having children with her, has anything changed in the relationship between
287. you and your wife?
288. R Ah, as of now, not yet.
289. I And 'not yet', do you think that it might in the future?
290. R Ah not yet, I don't know, maybe in the near future.
291. I uhu
292. R But as a woman, ah there's no change. There is cooperation,
293. I uhu
294. R Yah, that's why we are travelling ( ) together let us search for this way,
295. and that way
296. I yah
297. R then okay. So that's why we are [end of tape, part missing] I say for example, maybe
298. she can say ah, then maybe we are not in e:h didn't make child ( ) maybe
299. let me try somewhere else. Maybe. The change can be there.
300. I Uhu
301. R Yah
302. I Yah
303. R Just, I'm just eh (.) supposing, rather than [(.) ( )
304. I [ya:h
305. R hhuhu.
306. I Ya:h, yah of course.
307. R Hhuhu

There are three features of the responses in extracts 1 to 3 which I want to point out. First, respondents deny that anything changed in their relationship. They do this by means of direct denials, 'a:h no' (extract 1, line 645) and 'no' (extract 2, line 188), 'not yet' (extract 3, line 288), and a description of their relationship which indicates that no change took place: 'it's the usual situation', 'the usual', and 'no any change (…) no any transformation of any kind' (extract 1, line 645-647), 'our love for one another is still the same up to this moment' (extract 2, line 188-190) and 'there's no change' (extract 3, line 292).

Second, in extract 3, the respondent attends to, but rejects, the possibility that his relationship changes. The respondent starts his response to the question whether anything has changed in the relationship between him and his wife with 'as of now, not yet' (line 288). Thereby he implies that a change may take place in the future, an inference picked up by the interviewer (line 289), and confirmed by the respondent (line 290). In line 299 the respondent states explicitly: 'Maybe. The change can be there' in that his wife says 'maybe let me try somewhere else' (line 298-299), and thus decides to try to make a child with someone else. However, the respondent makes clear that his wife's decision to try somewhere else is merely a hypothetical possibility, rather than a reality, in part by aforementioned denials of change and by saying 'I'm just eh (.) supposing, rather than (.)' (line 303).

By attending to the possibility that his wife 'tries' with someone else, the respondent appears to take into account the assumption that his relationship may change. Such an assumption can reasonably be expected to be 'live' to the conversation, first of all due to the interviewer's question. By asking about changes in the respondent's marital relationship, the interviewer suggests that she considers it at least possible that the respondent's relationship changed. In addition, assumptions that relationships change, for instance due to polygamy or extramarital affairs, can be expected to be relevant considering respondents' orientation to forms or marriage breakdown as culturally required response to fertility problems (see chapter 4). For, this suggests that the idea that infertility normally leads to marriage breakdown is a culturally shared notion, which the respondent may be attending to. The apparent relevance of assumptions that certain marriage 'issues' can occur, makes attending to the possibility of relationship change, but rejecting its reality, a particularly effective way of persuasively constructing one's relationship as, so far, unchanged.

A third feature which the responses have in common is that the respondents characterise their relationships as good. They do this to begin with by referring to positive aspects of their relationship. In extract 1, the respondent mentions 'our love for one another' (line 191), in extract 2 'we are discussing friendly, politely' (line 651-652), and in extract 3 the respondent points out that 'there is cooperation' (line 292). The respondent warrants this claim by providing supportive evidence: 'we are travelling ( ) *together*', searching 'this way, and that way' (line 294-295). In

addition, the respondents, and in extract 2 the interpreter, deny the presence of any negative aspects to their relationship. In extract 1, the respondent states 'no any shaken' (line 649), which can be taken to mean that the relationship is not disturbed. In extract 2, the interpreter states 'there's no need to disturb about their love' (line 201-203). This statement is somewhat ambiguous, but seems to imply either that the respondent's and his wife's love has not been 'disturbed', or that one does not need to 'be disturbed', in the sense of worrying about it. In either case, the interpreter denies that the respondent is experiencing relationship troubles. These denials of negative aspects to their relationships make the respondents' construction of their spousal relationships as good more convincing.

Note that also in extracts 1 and 2, the same assumption regarding the possibility that negative changes in spousal relationships occur appears relevant, for the same reasons as mentioned before. This may explain the respondents' persuasive design of their claims that their relationships are good.

Respondents also construct relationships with other people than their spouses as unaffected. In extracts 4 and 5, respondents with fertility problems respond to questions about whether anything changed in their relationships with others. In extracts 6 and 7, 'significant others' of someone with a fertility problem were also asked about changes in their relationships with them.

Extract 7:4 Int. 44 inf.w

341. I Okay. A:nd what about relationships with other people, maybe other family
342. members, or friends, neighbours, did anything change in your relations
343. with them?
344. R hh. No anything but, when we chatting, no anything changed. We are
345. just staying (.)chatting.
346. I uhu
347. R Yah

Extract 7: 5 Int.14 inf.w[38]

151.I Mmm ok ah has
152. anything changed in
153. your relationships with
154. other people since you
155. have started problems
156. of not having a child
157. for example friends,
158. ( ) your parents?
159. T *Is there any change in the*

[38] Due to the high costs involved in translation, I was unable to get the chichewa transliterated.

160.		*relationship with the people*	
161.		*around you as regards the*	
162.		*problem?*	
163. R		*A:: h nothing.*	
164. T	She's saying nothing		
165.	goes wrong.		
166. I	Mmm okay, ehm did		
167.	anybody start to treat		
168.	you or your husband		
169.	any differently?		
170. T		*Is there a problem because of*	
171.		*this problem. are there*	
172.		*problems between you and*	
173.		*other people and between your*	
174.		*husband and other people*	
175.		*because of this problem?*	
176. R		*A::h but, we are living in*	
177.		*harmony, really, yes.*	
178. T		*With your neighbours?*	
179. R		*Hm*	
180. T	She is saying that		
181.	there is no problem		
182.	with outsiders		

Extract 7:6 Int. 35 s.o

1308.	I	Yah, okay. And did your relationship change in anyway with your
1309.		brother since he failed to have children?
1310.	R	In my case no.
1311.	I	No.
1312.	R	(Nay) (because/ it was) not something of his own making.
1313.	I	Uhu
1314.	R	It's not something which he asked for, [no.
1315.	I	[Okay
1316.	R	So: there's nothing: that should affect our relationship between him and me.

Extract 7:7 Int. 13 s.o

670.I	Hmhm, yeah that's		
671.	fine. Ehm, has		
672.	anything changed in		
673.	the relationship		
674.	between you and your		
675.	daughter since she has		
676.	noticed that she fails to		
677.	have children?		
678. T		*Has your relationship with your*	Chibale chanu chinasintha
679.		*daughter changed since you*	chinayambapo chasintha pa
680.		*realized that your daughter*	nkhani imeneyi yokuti iye alibe
681.		*cannot have a child?*	mwana?
682. R		*No it hasn't changed*	Ayi sichinansinthepo.
683. T	She's saying no.		
684. R		*Even this house in which I stay*	Kutereko nyumba ino ndikhala
685.		*belongs to her.*	ino ndiyakenso.
686. T	She's saying that the		
687.	house where she's		
688.	staying is for her		
689.	daughter.		

The responses in extracts 4 to 8 exhibit features which are similar to those seen before in replies to questions about changes in marital relationships. First of all, respondents make clear that no changes took place. They do this by means of direct denials: 'no anything (…) no anything changed' (extract 4, line 344-345), 'a::h nothing' (extract 5, line 163). Also the respondents in extracts 6 and 7 explicitly deny that their relationship with their brother (extract 6) and daughter (extract 7) changed: 'in my case, no' (extract 6, line 1310), 'there's nothing that should affect our relationship between him and me' (extract 6, line 1316) and 'no it hasn't changed' (extract 7, line 682). In addition, the respondent in extract 4 states 'we are just staying' (line 344-345), 'Staying' suggests that her relationships continue as they were, and thus did not change. 'Just' (line 344) appears to support the notion that nothing out of the ordinary is going on, by fulfilling a depreciatory function (Lee, 1984) of playing down the importance of 'staying'.

Second, the respondents construe their relationship with others as good. They do this by making relevant positive aspects of their relationships. The respondent of extract 4 indicates that she and others are 'chatting' (line 344-345). As 'chatting' is a recognizably friendly, and moreover, ordinary activity between family, friends or neighbours, the respondent thereby makes relevant the good, ordinary and unproblematic nature of her relationships. In extract 5, the respondent does this by saying 'we are living in harmony' (line 176-177). The respondent in extract 7 makes relevant the good quality of her relationship with her daughter when she says 'even this house in which I stay belongs to her' (line 684-685). By making clear to be sharing property with her daughter, the respondent occasions the inference that there are no, or at least no significant, complications in their relationship. In extract 7, by saying that there is nothing which should *affect* our relationship (line 1316), the respondent makes clear that no negative changes have taken place and thus that his relationship is good.

The respondents in these four extracts make their claims that their relationships did not change, and that their relationships are good, convincing. In extracts 4, 5 and 6, the respondents use extreme case formulations (ECFs) in their denials of change: 'no anything', mentioned twice in line 344 of extract 4, and

'nothing' (extract 5, line 163; extract 6, line 1316). The ECFs make the claims that no changes occurred rhetorically strong, by ensuring that the strongest case of the argument is provided (Pomerantz, 1986). The respondent in extract 5 emphasizes the good quality of her relationships by means of the additional 'really' and 'yes' at the end of the sentence 'we are living in harmony, *really*, *yes*' (line 177). By means of 'really', the respondent attends to and rejects the idea that her claim is not 'really' true. Furthermore, the respondent in extract 6 makes his claim that nothing changed in the relationship with his brother by providing an account for his claim: '(it was) not something of his own making' and 'it's not something which he asked for, no' (line 1312-1314). Hence, the respondent constructs his brother as not to blame for his fertility problem, and thereby warrants his claim that nothing has affected, or should affect, their relationship. In addition, the respondent makes clear not only that nothing has changed, but also that this is what *ought* to be the case when he says 'there's nothing that *should* affect' (line 1316). This is another way in which the respondent makes his claim more convincing.

As seen before, the persuasive design of respondents' claims, in particular the use of extreme case formulations, appears to be related to and deal with assumptions built into the interviewer's questions, namely that some changes may have taken place. Pomerantz (1986) has pointed out how extreme case formulations can pre-empt a sceptical response to one's claims. The potential of a sceptical response seems pertinent especially the case in extract 5, as by means of her probe (lines 166-169), the interviewer pursues the issue of whether the respondent's relationships have changed after she has denied (line 162) that any changes took place. As said, the respondent's 'really' (line 177), as well as her addition of 'yes' to her claim that she is living in harmony, appear designed to inoculate her claim from doubts. In extract 8, the respondent can be seen to take into account assumptions that in principle relationships with people who have fertility problems may change. The respondent starts his response with '*in my case*, no' (line 1310). By restricting the lack of change to his 'own' case or relationship, the respondent makes relevant that in other cases, relationships with people who have fertility problems may change. As in extract 3, by attending to the possibility that relationships change but denying that

this is happening in his own case, the respondent makes his denial that any change took place in his relationship with his brother persuasive.

So far then, I have shown how respondents persuasively deny that their marital, family and community relationships changed and construct these relationships as good. In so doing, they appear to attend to and inoculate assumptions, in part built into the interviewer's question that their relationships changed for the worse. These observations are unexpected and surprising. This is so first of all considering the literature, which emphasizes that infertility affects people's relationships, and characterises infertility as 'a disease of social relations'. Second, one would expect respondents to refer to changes in their marital relationships considering that, as discussed in chapter 4, respondents attend to forms of marriage breakdown as culturally required solution for fertility problems.

7.2 Attending to relationship troubles

At times, respondents do address changes and problems in relationships with their spouses, family or community members. In this section, I will focus on how respondents describe such changes and troubles, to begin with in marital relationships.

7.2.1 Playing down the significance of extramarital affairs

Extracts 8 to 10 are examples of extracts in which respondents indicate that certain changes in their marital relationships took place, such as extramarital affairs. Consider extracts 8 to 10.

Extract 7:8 Int. 28 inf.w

173.	I	ehm did anything ↑change in the relationship between you and your husband?.
174.	R	Ah not much. But eh I remember, some time back, he was going at- here and
175.		there. Hhu (maybe)hhu looking-hhu ·hh hha >I believe< seahhurching for
176.		other women:
177.	I	hmhm
178.	R	(in order) to try maybe to try, maybe he can have (a child) but eh ah I don't-
179.		that is, for <u>me:</u>
180.	I	Uhu
181.	R	I don't believe much, because I love him and he loves me=
182.	I	=Uhu
183.	R	He [loves me,
184.	I	[Okay:
185.	R	So that is, it's not eh (1) ◦ahm◦ (2)

((some lines omitted, some lines are missing due to tape ending))

191. R hhuhuhu ·hh eeh (he) don't like that.
192. I Okay. Because it's growing, what is growing?
193. R I mean it's getting ah, (2) he's becoming now a real man (leaving) childish life, to
194. growing up of mind, ah.
195. I So::: do you mean that
196. R I I mean that if e a man hhuhu is eh it's a youth , he likes going away with
197. other women.
((some lines omitted))
204. I Okay He's less childish he he, did he stop [doing that now?
205. R [eeh he stopped doing.
206. I Okay=
207. R =Going with other women.
208. I Okay.

Extract 7:9 Int.12 inf.w ((the respondent told the interviewer before that her current husband started doing 'the same' as a previous husband, who got a girlfriend and divorced her because they did not have any children.))

122.I	Okay. Yah.		
123.	((cough)) So ehm. Has		
124.	the husband with whom		
125.	you are now, ehm has		
126.	he already (.5) looked,		
127.	has he been looking for		
128.	another woman eh to:		
129.	have children, with?		
130.T		*She is asking whether your*	Ati mwamuna amene muli naye
131.		*present husband is also looking*	panopa amuna anuwa
132.		*for another woman to have*	akupanganso kapena
133.		*children with?*	kukayangana mkazi, wina kuti
134.			akhale ndi ana panopa?
135. R		*No he did that during the past*	ayi anangopana zaka
136.		*years.*	zambuyomuzo
137. T	Okay. Saying no, she		
138.	did that later years but		
139.	now she [he]'s not doing		
140.	that.		
141.I	Okay.		
142. R		*It was a mere relationship but*	Chinangokhala chibwenzi eya
143.		*he made her pregnant and there*	ndiye anaperekako mimba
144.		*is a baby-boy who is now like*	kubadwa mwana wamamuna
145.		*this ((indicates height with*	kumene kuja mwana wathu ali
146.		*hand)), but now he no longer*	chonchi, ndiye kumeneko anayi
147.		*goes there.*	mika.

148. T Okay she said he had a
149. girlfriend then she [he]
150. got her pregnant and
151. then she has a small
152. boy, right now. The
153. second husband.
154. I O:kay,
155. T Yah.
156. I The s- the the current
157. husband.
158. T hmhm:
159. I Okay.
160. T yes.
161. I Uhu.
162. T But now (.)
163. she's settled

Extract 7:10 Int.12 inf.m

605.I	Okay. Can you tell me		
606.	a bit about how you		
607.	felt about that when		
608.	you found out that he		
609.	was seeing someone		
610.	else?		
611.T		*How did you feel when you*	Inuyo munamva bwanji
612.		*heard that your husband has*	mutamva zoti amuna anu apeza
613.		*found a girlfriend somewhere*	chibwenzi pena pake?
614.		*else?*	
615.R		*In my heart eee I felt (.) I asked*	Mumtima mwanga eee
616.		*him because I saw that my heart*	ndinamva (.)ndinawafunsa
617.		*pains me a lot that he wants to*	iwowo ndinaona mtima
618.		*go away when he is the one who*	unandipweteka kwambiri
619.		*supports me, not so? Then I*	kuti afuna ati achoke pomwe
620.		*asked him what was the idea*	amandithandiza eti ndiye
621.		*behind all this, what are you*	ndinafunsa maganizo awo kuti
622.		*thinking of, then he told me his*	mukuganiza bwanji, ndiye
623.		*problem that a a a the problem*	anazanena mavuto awo kuti a a
624.		*that I have is not any other*	a ine vuto limene likundivuta
625.		*problem but the problem that is*	ine palibe vuto liri lonse koma
626.		*troubling me is that of not*	vuto limene likundivuta ine
627.		*having children eee so maybe if*	ndikulephera mphatso eee ndiye
628		*I go here and there I might get*	mwina ndikapita kwina kwina
629.		*a child. So this discussion*	mphatso ndikayipeza ndiye
630.		*went to the elders who came*	mpaka nkhanizi zinapita kwa
631.		*and discussed with us and gave*	anthu. oweruza ndikubwera
632.		*a final solution.*	ndikuweruza.
633.T	She is saying that she		
634.	felt painful and asked		
635.	the man and the man		
636.	said that the problem is		
637.	that I don't have kids		
638.	with you so I want		
639.	to have the kid.		

In extracts 8 and 9, the respondents indicate that their husbands were having extramarital affairs. The respondent in extract 8, asked whether anything has changed in the relationship with her husband, provides a qualified negative response: 'ah not much' (line 174). Thereby she can be seen to imply that some minor changes did take place. The respondent makes clear that these changes concern her husband going 'here and there', 'seahhurching for other women:' (line 175-176). In extract 9, the interpreter asks the respondent 'whether your present husband *is* also looking for another woman?' (line 132). The respondent replies 'no he did that during the past years' (line 135-136), thereby making clear that her husband used to look for other women. In extract 10, the same respondent as in extract 9 elaborates on her description of her husband's affair, in response to the interviewer's question about how she felt when she found out that her husband was seeing someone else.

Respondents' descriptions of their partners' affairs have several features in common, which as I will show, serve the function of playing down the significance of the relationships. First, in extracts 8 and 9, the respondents locate their husbands' extramarital relationship in the past. They do this by referring to 'some time back' (extract 8, line 161) and 'during past years' (extract 9, lines 135- 136), using past tenses, for instance in 'he *did* that' (extract 9, line 136), 'it *was* a mere relationship' (extract 9, line 142), 'he *was* going' (extract 8, line 174), and, in extract 8, by means of the respondent's remark 'I remember' (line 174). Furthermore, both respondents make clear that their husbands' affairs are over. The respondent in extract 9 states that 'now he no longer goes there' (line 146). In extract 8, the respondent points out that her husband is 'becoming now a real man (leaving) childish life, to growing up of mind, ah.' (lines 193-194). As 'childish life' can reasonably be assumed to refer to her husband's search for women, the respondent implies that her husband ended his affairs. This understanding is displayed by the interviewer's probe: 'did he stop doing that now'? (line 204), and confirmed by the respondent: 'eeh he stopped going' (line 205)**.** By making clear that the affairs belong to the past, respondents make them less important for their relationships now.

Second, respondents construct their husbands' affairs as impersonal. In extracts 8 and 10, the respondents speak about their husbands going 'here and there'

(extract 8, line 174; extract 10, line 628). Thereby they suggest that their spouses were not having an affair with anyone in particular. In extract 8, the respondent also suggests that her husband was not going for a specific person by referring to her husband's 'searching' (line 161), and describing the object of the search as 'other women' (line 161), in the plural. Furthermore, the respondents construct their spouses' affairs as impersonal by making relevant an instrumental motivation as informing their husbands' affairs: wanting to have a baby. This is done most clearly in extract 10. The respondent points out that, asked 'what was the idea behind all this' (line 620-621), her husband answered: 'the problem that I have is not any other problem but the problem that is troubling me is that of not having children' (line 623-627). The respondent makes relevant not having children as motivation for her husband's extramarital affair also when she reports that her husband said 'so maybe if I go here and there I might get a child.'(line 627-629). Likewise, the interpreter does this by reporting that the husband said 'the problem is that I don't have kids with you so I want to have the kid'. (line 636-639). In extract 8, the respondent appears to allude to their husbands' motivation as wanting to have a baby when she states that her husband was searching for other women '(in order) to try maybe to try, maybe he can have (a child)' (line 178). Although 'child' is not clearly audible, it is a reasonable ending considering the first part of the sentence. By constructing their husbands' affairs as based on instrumental motivations, respondents suggest that they do not necessarily reflect the quality of their current relationship.

A third way in which respondents play down the significance of their husband's affairs' can be observed in extract 8. The respondent provides an account for her husband's affair: 'if e a man hhuhu is eh it's a youth, [then] he likes going away with other women' (line 193). The implicit if-then construction makes going away with other women into law-like, and thus common and predictable behaviour for youthful men (Edwards, 1995). This is thus a script formulation (Edwards, 1994, 1995), which constructs events or actions as common, routine and predictable. The respondent uses other scripting devices as well, such as what Edwards (1995, p. 27) calls 'citing a disposition' (Buttny, 1993), in 'he *likes* going away' (line 196). By making clear that young men like going away, she portrays them as generally inclined, or dispositioned, to do so. In addition, the respondent refers to 'a man' and

'a youth' in a generic sense, which implies that the described behaviour applies to young men in general. By making her husband's affairs instances of a common pattern of behaviour amongst young people, the respondent constructs them as normal and thus plays down their significance, in that they do not (necessarily) reflect the quality of their relationship.

A fourth, and last way of minimizing the significance of extramarital affairs I want to address can be seen in extract 9. In line 142, the respondent states that 'it was a mere relationship'. She attends thereby to the relationship as being of relatively little importance, and thus as innocuous.

Thus, the respondents describe their partner's affairs in such a way that they play down their seriousness. As a result, respondents forestall the inference that their relationship is bad. Indeed, the respondents, and in extract 9 also the interpreter, construct their relationship as good. The respondent in extract 8, attends to the good quality of her marital relationship when she states 'I love him and he loves me' (line 181). She stresses her husband's love for her by repeating this 'he loves me' (line 183). In extract 9, the interpreter describes the respondent and her husband as 'settled' (lines 163). In extract 10, the respondent can be seen to attend to the good quality of her relationship when he points at the absence of problems: 'not any other problem but' (line 624-625).

7.2.2 Not complaining about relationship troubles

Examination of respondents' descriptions of relationship troubles, regarding their marital and other relationships, suggest that there are certain interactional sensitivities which come into play which respondents have to deal with.

To begin with, returning to extracts 8 to 10, it is noticeable that the respondents' descriptions of their husbands' affairs do not include an assessment: the respondents do not provide their opinion or a judgement about their husbands' extramarital relationships. This is somewhat surprising, as according to common sense understandings, husbands having an affair are troublesome, likely to be hurtful and thus 'complainable matters' (Drew & Holt, 1988). This makes negative assessments and complaints expected and reasonable. In extract 10, the interviewer asks the respondent explicitly for an assessment of the husband's relationship when

she asks how the respondent 'felt about that' (line 607), that is about 'when you found out that he was seeing someone else' (line 608-610). In so doing, the interviewer makes relevant that the respondent has so far not yet displayed her opinion or judgement regarding her husband's affair. However, this explicit request does not result in an assessment either. The respondent describes her own feeling: 'I saw that my heart pains me a lot' (line 616-617). The interpreter translates the interviewer's question as 'how did you feel when you heard' that your husband has found a girlfriend' (lines 611-613), and thus asks for the respondent's feeling rather than an assessment of her husband's affair. However, it should be noted that, as noted by Drew (1998) and Holt (2000), speakers *can* provide implicit assessments also whilst describing their feelings. For instance a statement like 'I was angry' constitutes a feeling and an assessment. Hence, it apperas that the respondent could reasonably have provided an assessment, but does not do so. When the respondent provides a reason for her 'painful' feeling, she evades an assessment of her husband's affair as well. The respondent explains that 'I saw it very painful that he wants to go away while he is the one who supports me' (line 616-619). Here, the respondent identifies her husband's leaving her, rather than his affair in itself, as painful and thus problematic.

In some instances, respondents describe changes in their relationships with others, and thereby make relevant other people's problematic behaviour. Also in these descriptions, assessments appear remarkably absent. Consider extracts 11 to 13.

Extract 7: 11 Int. 44 inf.w ((continuation of extract 13, in which respondent stated that 'no anything' changed in her relationships with others))

350. I Were there perhaps people who started to treat you differently when you
351. were not having children for a while?
352. R. (1) Eeh, ( ) say that 'Why you don't have any children? What is your
353. problem?' (.5)(Myself) I say that 'Ah, I don't know.' So she: ask me that
354. (.) your husband he have a: another she has a, he have a he have
355. children. No:: he don't have, I am the first wife!.
356. I Uhu
357. R Yah

Extract 7:12 Int.3 inf.m

196.I Okay. I see, okay
197. Hmhm. Ehm so we've
198. talked about the
199. relationship with your
200. wife, and now I

201. was wondering about
202. the relationship with
203. others you know,
204. either people you know
205. very well, or family
206. members or friends or
207. people you know not
208. so well, who for
209. example live in your
210. village.

211.T	*Now she is saying. She has*	Tsopano apa akunena kuti
212.	*understood how you live in your*	adziwa mmene mukukhalira
213.	*family and how things are. But*	mbanja mwanu, ndi pamene
214.	*now she wants to know what*	ziliri. Tsopano akufuna kuti
215.	*the people around the village*	inuyo kwa anthu ozungulira
216.	*say about you.*	kumidzi amanena chani za inu?
217. R	*Ooh. Its like people around us*	Ooh. Kungoti kwa anthu
218.	*in the village, ah, what I meet is*	ozungulira kumudzi ah, zimene
219.	*that some people speak bad*	ndimakumana nazo ndizonena
220.	*about our marriage because we*	kuti anthu ena amanyoza banja
221.	*don't have children.*	lathuli chifukwa chakuti tilibe
222.		ana

((some lines omitted in which respondent talks about 'temptations' like meeting women who want to fall in love with him.))

236.T He's saying that (.5)
237. people. Said much
238. things on this, and they
239. (.) getting be ashamed
240. [because of people are
241.T [hm
242.R talking of this, you
243. don't have children
244.I Okay

Extract 7:13 Int. 44 inf.w ((respondent has just said in response to the question why she wants to have children that 'this is our culture' and 'if you (are/feel) married, you must have the children))

155. R So my parents, our parents say that ah, she's barren she's
156. barren,
157. I Uhu
158. R Go away, go away.
159. I Hm::
160. R Hm:
161. I Go away?
162. R Yeah- go away. She's barren. Marry another woman.
163. I Uho
164. R Yah
166. I Okay. How did you feel about that when they were saying that?
167. R I was just staying. And pray.
168. I Uhu
169. R Yah. (.5) Maybe crying.
170. I Uhu
171. R Uh. So my husband said that ah, don't cry. (2) Hm.
172. I Hm
173. R Hm

All three respondents describe behaviours of others which can be expected to be in some way troublesome for them. In extract 11, the respondent is asked whether there were perhaps people who started to treat her differently (line 350). She confirms this with 'eeh', which is Chichewa for 'yes' (line 352). She then makes clear that people ask her 'Why you don't have any children? What is your problem?' and suggest that 'your husband he has a another he have a he have children.' (lines 353-354). Especially this suggestion is conceivably troublesome for the respondent, as by proposing that her husband has children, the respondent is put forward as the one who has the fertility problem, and is thus to blame for it. In extract 12, the interpreter translates the interviewer's question as 'now she wants to know what the people around the village say about you' (line 214-216). In response, the respondent indicates that 'what I meet is that some people speak bad about our marriage because we don't have children.' (line 218-221). Being spoken about in a bad way is recognizably problematic for the respondent, and attended to as such by the interpreter, when he states that the respondent and his wife are 'getting be ashamed' because of what people say (line 239). The respondent in extract 16, describes how 'our parents' told her and her husband that 'she's barren she's barren (…)' (line 156), that she should 'go away, go away' (line 158, 162) and that her husband should 'marry another woman' (line 162). From what the respondent said before, it can be inferred that she is referring to her parents in law. These comments appear hurtful for the respondent. As said before (chapter 6), a command like 'go away' formulates a request to leave in the harshest possible way (Widdicombe & Wooffitt, 1995). Thus, the respondent formulates her parents' in law behaviour in such a way that it can be inferred to be harsh and dismissive, and thus problematic or hurtful, especially considering that this 'request' comes from the respondents' parents in law.

The responses in these extracts 11 to 13 differ from those shown before, in which respondents construct their relationships with others as good (extracts 4 to 7). One difference between the two sets of extracts is the question asked. In extracts 4 to 7, the respondents are asked whether there are any changes in the relationship *between* them and others. This is not the case with the questions asked in extract 11, 'were there perhaps people who started to treat you differently when you were not having children for a while?' (line 350), and in extract 12 'now she wants to know

what the people around the village say about you' (line 214-216). These questions ask about how other people treat the respondent. The difference in respondents' constructions of their relationships could be related to the differences in this question. This is also suggested by the observation that the respondent in extract 4 is the same as the respondent in extract 11, who thus at first constructs her relationships as unchanged and good, and then points at some change in behaviour of others towards her. I will return to this issue of how reports of problems may tie in with the question asked in the next section.

The descriptions of others' conceivably problematic behaviour come across as objective, factual reports. In extracts 11 and 13 this is so because of the use of reported speech (Holt, 2000; Hutchby & Wooffitt, 1998), more specifically, *direct* reported speech (Holt, 2000). In direct reported speech ('he said x'), utterances are reported from the perspective of the original speaker, while in indirect reported speech ('he said *that* x'), the utterance is related from the point of view of the current speaker (Coulmas, 1986, Holt, 2000). Therefore, it has been argued that whereas indirect reported speech is relatively easily infiltrated by the reporter's comments and interpretation (Holt, 2000), direct reported speech comes across as an objective portrayal of previous utterances (Holt, 2000; cf. Hutchby & Wooffitt, 1998; cf. Voloshinov, 1971). In addition, Holt (2000) explains how direct reported speech, by suggesting to reproduce the original utterances, reproduces both the original speaker's words *and* the action which he or she engaged in. Therefore, by using direct reported speech, speakers can give recipients access to the actions performed, enabling recipients to judge their moral character for themselves without having to indicate this.

Regardless of this neutral quality to direct reported speech, Drew (1998) and Holt (2000) have pointed out that it is often used in the making of (implicit) complaints. Speakers can make complaints whilst using reported speech in several ways. First, speakers can implicitly convey their own assessment of the reported speech. For instance, Holt (2000) explains how using a particular gloss to introduce a description of behaviour, such as 'I'm broiling about something' provides for its complainable character. In addition, prosodic features (Drew, 1998; Holt, 2000) can be used to portray others' speech as insulting or otherwise morally untoward, for

instance by adopting a 'mock innocent tone' (Drew, 1998, p.323). However, in extracts 11 to 13, the respondents make use of none of these devices to implicitly assess the reported behaviour. Second, both Drew and Holt (1988) and Pomerantz (1978) note that blamings tend to occur *after* neutral reports of 'unhappy incidents' (Pomerantz, 1978), which detail the grievance. Thus, a complaint tends to be a separate, second part of descriptions. This part is 'missing' in extracts 11 to 13. Assessments are noticeably absent, because as explained above, the reactions could reasonably be characterized as troubling and unpleasant for the respondents. In extract 13, the interviewer attends to an assessment as being noticeably lacking, as she explicitly asks for one in her probe (line 166): 'How did you feel about that when they were saying that?'. In response, the respondent first describes her actions, namely 'just staying' and 'pray' (line 167), rather than her feeling about what her parents were saying. Thereby she avoids meeting the interviewer's request for an assessment. In line 169, the respondent adds 'maybe crying'. She thereby makes relevant another activity, which implies a negative emotional state, that is it implies that the behaviour of her parents' in law made her feel sad. However, it is not an *assessment* of her parents' behaviour, that is it does not show the respondent's opinion or judgment of what they said to her.

Hence, the extracts presented in which respondents address others' conceivably problematic behaviour are of a strikingly neutral quality, and respondents appear to avoid providing assessments of relationship troubles which they describe. It has been noted that in general, moral activities such as complaining are sensitive issues (Linell, 1998), which has been related to observations that moral activities such as blaming and complaining are often done implicitly (Drew, 1998; Holt, 2000). Considering that in these extracts assessments are absent rather than implicit, complaining about others' behaviour within the context of changes in relationships between people with fertility problems and others, appears to be a particularly sensitive issue.

In the next section, I will explore some interactional and interpersonal issues which make addressing relationship troubles and assessing them delicate matters.

7.2.3 Moral sensitivities in addressing and assessing relationship troubles

I have argued that making relevant relationship troubles and in particular complaining about this and others' behaviour are dispreferred, sensitive activities. Linell (1998) argues that one of the reasons why engaging in moral activities, such as blaming, is a sensitive issue, is that one risks becoming the object of moral activities, that is one risks being blamed oneself. This appears to be one of the issues respondents in my data are dealing with as well. This is suggested first of all by the observation that in all extracts discussed so far, in which men and women with a fertility problem are asked whether their relationships with others changed, they construct their relationships as good, whereas when asked whether other people started to treat them differently, respondents do attend to relationship troubles. The question whether there are any changes in the relationship *between* respondents themselves and others can be characterised as 'bidirectional', in that any positive responses do not indicate whom is responsible for the relationship changes; this could be either the respondent or the others. Questions which ask about how other people treat the respondent can be characterised as 'unidirectional', because these others can be more readily be held responsible for any problems put forward than the respondents themselves. Hence, it can tentatively be suggested that addressing relationship problems can be a delicate issue, as respondents can be held responsible for any problematic changes, an issue particularly pertinent to responses to 'bidirectional' questions about changes in relationships. Extract 14, displayed below, supports the idea that one of the risks which respondents have to manage when addressing relationship problems is being blamed themselves. This extract deviates from the aforementioned pattern. The respondent addresses relationship troubles when asked a 'bidirectional' question about changes in relationships. In addition, the respondent can be seen to complain about others' behaviour. However, in line with my previous suggestions, the respondent indeed attends to the interactional problems this raises, specifically the potential of being seen himself as to blame for the relationship troubles.

Extract 7:14 Int. 47 inf.w/m

691. I Okay, yah. And what about if you think about relationships with other people you

692. know, other family members, or friends or neighbours, are there any changes in
693. relationships with them?
((some lines omitted in which the respondent makes clear that their neighbours laugh and shout at them sometimes))
713. Rm They provokes us. (.5) ↑Yah. They do provoke.
714. I How?
715. Rm E:h you know, whenever men they are together, I am discussing we're
716. discussing something about our family affairs with my wife,
717. I yah
718. Rm we are at our house, you see that they are discussing, a story concerning <u>us</u>,
719. maybe: including us in their story.
720. I Uhu
721. Rm Ah you you are still young, like that.

In response to the interviewer's question whether his relationships with 'other people' he knows have changed, the respondent indicates that others laugh and shout at him, and 'provoke us' (line 713). He thus makes relevant others' problematic, blameworthy behaviour. At the same time, the respondent inoculates himself from being blamed for it. He does this first of all by constructing others as provoking him and his wife, which he underlines by referring to it twice in line 713, by saying 'they *do* provoke' and by the 'yah' with heightened intonation. Provoking others is behaviour which is by definition initiated by the actor, who incites others. Therefore, the respondent allocates an active role to his provocative neighbours, and a passive, victim role to himself and his wife. As a result, he blames his neighbours, and inoculates himself from being blamed.

Second, the respondent uses a contrast structure (Dickerson, 2000; McKinlay & Dunnett, 1998; Widdicombe & Wooffitt, 1995) to divert blame away from himself and his wife to others. Asked 'how' his neighbours provoke him and his wife (line 714), the respondent first provides a description of their own behaviour: 'we're discussing something about our family affairs with my wife (line 716). The respondent makes clear that he and his wife discuss private issues, namely 'family affairs' (line 716), and contrasts this with the neighbours' behaviour: 'they are discussing a story concerning <u>us</u>, maybe including us in their story' (line 718-719). The respondent here implies that the others' topic of discussion is *not* their own private family affairs. In addition, the respondent appears to indicate that whereas he and his wife have their discussions in a private setting, namely 'at our house' (line 718), the neighbours talk about them publicly. For, he points out that when 'we are at our house, *you see* that they are discussing' (line 718). By contrasting others'

problematic behaviour with his own unproblematic, innocuous behaviour, the respondent attributes blame to others for their behaviour and inoculates himself from being blamed. Other authors too, have noted that contrast structures can be used to make a complaint about others' behaviour (Widdicombe & Wooffitt, 1995) and to cast the speaker in a favourable light (McKinlay & Dunnett, 1998; Dickinson, 1999).

The respondent's construction work makes sense in the light of the aforementioned problem that addressing relationship troubles can raise the question of who is responsible, or to blame for the trouble. One way of solving this is by constructing others' actions as blameworthy, and one's own behaviour as unproblematic. In so doing, the respondent avoids being suspected to have provoked other people's negative attitudes and reactions. The aforementioned constructions of relationships as good, playing down the significance of relationship troubles, and not complaining about others behaviour can be seen as other methods in which respondents deal with the delicacies involved in addressing relationship troubles. In the next section, I will discuss another strategy which respondents use to manage moral issues in describing relationship problems.

7.2.4 Constructing others as not blameworthy

At times, respondents do not only not complain about others' behaviour, but actively forestall the perceptions that others' behaviour is 'complainable' and blameworthy. Consider extracts 15 to 17. In extract 14, the respondent is talking about his brother's behaviour, in extract 15, about his brother's relationships with others, in extract 16, the respondent addresses her own relationships with women in the community.

Extract 7:15 Int 48. s.o ((respondent has just mentioned that his family was 'affected' by his brother's fertility problem, in part because 'it brings jealousy' when looking at your brother's children. The respondent explains that jealousy is shown when 'you don't share food with friends))

284. I yah and was that happening in your family, or?
285. R E:::h at one time, I could just hear that ah now he's just eating on his
286. own, and so on. So to me I know anyway, I knew that's normal what
287. else could he have done. He doesn't have children. Why should he
288. bring food to hhuhu to eat with people who <u>bring</u> their children?
289. I Uhu.
290. R Yah. So that's one thing.
291. I You did understand that he wasn't sharing his food with others
292. R Yah, yah, yah. Sometimes yes. You could share but sometimes you
293. have things that you cannot share.

Extract 7: 16 Int. 28 inf.w

186. I Okay, I see. Yeah. And if you ehm walk around here in the
187. neighbourhood in ((name town)). Ehm how how do you feel do you
188. think about , does this issue bother you that you don't have children if you deal
189. with others here, in the [community] .
190. R [yes some-] sometimes I get it (bored) and I feel shy.
191. I Hmhm
192. R To be among, among women those who have children.
193. I Okay
194. R Yes,
195. I Yah.
196. R eh but they don't laugh at me. But ah myself, I feel.
197. I Yah
198. R ah
199. I Okay
200. R Yes.

Extract 7:17 Int 35 s.o ((brother))

668. I Okay. And ehm, any other relationships which were also affected do you think by this
669. fact that he couldn't produce children?
670. R Eh, yah even friends,
671. I uhu
672. R yes, even friends. Because I said we are three, (we are two) my my my child is now in
673. standard one or my child now is ten years old, we started discussing. ↑Ah but, (he) is
674. very clever, he has nothing to talk about. So( ) whenever I'm in companies of
675. those boys or those men they always talk about their children,
676. I Uhu
677. R so I'm no longer going to, be in their company. >You see<
678. I O:kay
679. R Definitely, it means that relation has (.) been affected.
680. I Okay, so people e- like your brother might cut themselves off a bit from their [friends
681. R [↓<u>yes</u>
682. I because they don't really, can't talk about the same issues.
683. R It's not that those people will be avoiding you, but it's you who would be (.) avoiding
684. them
685. I Okay I see.
686. R because you don't have much in? Common.
687. I Yah, okay.
688. R Yes

Before extract 15, the respondent has just mentioned that fertility problems bring jealousy, for instance in the sense that 'you don't share food with friends'. Asked whether that was happening in his own family (line 284), the respondent acknowledges that 'at one time, I could just hear that ah now he's just eating on his own' (lines 286-287). Not sharing food can be seen as problematic behaviour, in particular in this case, as the respondent has just framed it as (an instance of) jealous behaviour. In extract 16, the respondent is asked whether it bothers her that she does not have children when dealing with others in her community (line 188-189). The

respondent acknowledges this and explains that 'sometimes I feel shy' (line 190), 'to be among, among women those who have children' (line 192). This could reasonably lead to the inference that other women behave in negative, problematic and thus complainable ways towards the respondent, thereby causing her shyness. In extract 17, the respondent makes relevant relationship troubles which his brother experiences when he acknowledges that his relationships with 'even friends' were affected (lines 670 and 672).

Thus in all three extracts, potentially problematic behaviour or relationship troubles are made relevant. However, the respondents construct respectively their brothers (extract 15), community members (extract 16) and 'friends' of their brother (extract 17) as not to blame for their behaviour or the trouble. They do this in various ways. First, in extract 15, the respondent explicitly classifies his brother's behaviour as 'normal' (line 286), and in so doing, as not blameworthy. Second, the respondent makes clear that his brother could not have acted in any other way by pointing out, by means of a rhetorical question, 'what else could he have done' (line 287-288) and that 'sometimes you have things that you *cannot* share.' (line 293). Authors like Watson (1978) and McHugh (1979) have argued that assessments of actions depend on whether people are thought to be in control of their actions and aware of their consequences, or in other words, whether the 'calculable choice model' (Watson, 1978) is applicable. The respondent makes clear that the 'calculable choice model' is *not* applicable to his brothers' behaviour, and thereby mitigates his brother's responsibility, and thus culpability for his behaviour (McHugh, 1975, Watson, 1978).

Third, the respondent in extract 15 portrays his brother as not to blame for his behaviour when he says in lines 287 to 289: 'Why should he bring food to hhuhu to eat with people who <u>bring</u> their children?' This is a rhetorical question, as it is not treated as requiring an answer by the interviewer, who responds with a continuer, nor by the respondent, who subsequently proceeds his turn. Due to its rhetorical nature, the question brings out that there is no reason why his brother should share his food. Consequentially, the respondent justifies his brother's refusal to do so. Note that the interviewer orients to the respondent's justification work when she provides as upshot 'You did understand that he wasn't sharing his food with others' (line 291).

A fourth way of constructing others' behaviour as not culpable can be seen in extracts 16 and 17. In these extracts, the respondents make clear that the troubles they report are not to be attributed to others, but to respectively themselves and (people with a fertility problem like) their brother. In extract 16, the respondent states that other women 'don't laugh at me, but ah myself, I feel' (line 196). She thus makes clear that her feeling of shyness is not due to others' behaviour, but, in some way, due to herself. The respondent in extract 17 makes clear that the change in the relationship between his brother and friends is not due to the friends' behaviour. He does this to begin with when he makes clear that his brother has 'nothing to talk about' (line 674), when in company of other boys or men, and points out the consequences of this: '*so* I am no longer going to be, in their company' (line 677). In so doing, the respondent makes relevant his brother's own decision to no longer be in his friends' company. Hence, he portrays his brother as having brought upon himself the change in his relationships with friends. This is reflected in the interviewer's upshot: 'people e- like your brother might cut themselves off a bit from their friends' (line 701). In addition, the respondent makes explicit that the agency does not lie with other people when he states: 'It's not that those people will be avoiding you, but it's you who would be (.) avoiding them' (line 683-684). Thus, the respondent makes relevant that his brother, and people like him, choose to avoid others' company, and are therefore responsible for any change, rather than others. This is sustained by the respondent's addition 'because you don't have much in? Common.' (line 686). He thus makes relevant a factual state of affairs of not having much in common as motivation for his brother's, and people's, avoidance of other people, rather than for instance others' problematic behaviour. Hence, the respondent forestalls that others are seen as to blame, for the affected relationship nor for his brothers' avoidance.

Constructing others as not blameworthy can be seen as another way in which respondents deal with the moral sensitivity of blaming others and the risk of being blamed themselves.

7.3 Summary and Discussion

In this chapter, I have shown how respondents persuasively deny that changes took place in their relationships with others, whether their spouse, relatives or the wider community, and construct their relationships as good. At times, respondents do address relationship troubles, with spouses, family, community member or friends. I have discussed how respondents can play down the significance of marital relationship troubles, that is extramarital affairs, do not complain about others behaviour and construct others as not to blame for relationship troubles. These observations suggest that addressing relationship troubles, and especially complaining about them and blaming others for them, are interactionally sensitive and dispreferred activities. I have suggested that one particular interactional issue respondents have to deal with is that they can be seen as to blame themselves for the troubles they address (cf. Linell, 1998). Two observations sustain this idea. First, relationship issues appear to be put forward more often in response to 'unidirectional' questions, which indicate who is to blame for any trouble put forward. Second, I have shown how a respondent who does construct others' actions as blameworthy in response to a 'bidirectional' question, inoculates himself from being blamed at the same time.

The analysis presented ties in with other authors' claims that moral activities like complaining and blaming are interactionally sensitive and dispreferred (Heritage, 1984, Linell, 1998; Pomerantz, 1989). Heritage (1984) argues that in general, talk-in-interaction is organized in such a way that it promotes solidarity, and avoids conflict. The sensitivities involved in blaming and complaining may be a particularly pertinent issue in my data, in part because of the relationships between the respondents and the people whose potentially troublesome behaviour is addressed. Complaining about, and blaming one's husband, brother, or community members goes against the grain of common sense expectations that marital, family, and community relationships are characterised by loyalty. Such activities could therefore lead to accusations of being a bad, unloyal spouse, sibling or community member. Respondents' constructions of relationships as good, playing down the significance of relationship troubles, not complaining about others behaviour, constructing it as not blameworthy, or contrasting it with one's own innocent

behaviour, can be seen as ways of dealing with delicate moral and interpersonal issues involved in addressing relationship troubles.

Some discrepancies can be noted between my findings and those reported in other qualitative, interview-based studies of infertility. First of all, whereas I have shown how at least some respondents construct relationships as good, the literature emphasizes the detrimental impact of infertility on people's relationships, although there is some variability and ambiguity in reports of the quality of relationships. My analysis sheds some light on both the discrepancy and the variability in research findings. It could be that in studies in which more relationship troubles are reported by respondents, more 'bidirectional' questions were asked, which ask for instance whether others started to treat respondents differently, or abusively, rather than whether relationships changed. Such questions seem to minimize the moral 'risk' of addressing relationship trouble and complaining about it.

A second, related difference between my analytic findings and the literature is that my analysis shows how respondents mitigate the seriousness of extramarital affairs, and still construct their relationships as good. In the literature however, extramarital affairs and other forms of marital instability are seen as one of the main hardships which especially infertile women have to endure. Nevertheless, some authors appear to have made observations similar to mine. Pashigian (2001) reports that one of the Vietnamese women he interviewed considered her husband to be a good husband, regardless of his affair with someone else whom he impregnated, and that men who take second wives are portrayed 'sympathetically' at times (Pashigian, 2001, p. 144). Gerrits et al (1998, p.22), mention that in Nigeria 'a husband is considered *'nice'* when he does not send his wife away when she cannot have any more children and instead takes another wife' (italics in original). Gerrits (1997) notes that some women accept that their men engage in extramarital affairs, and at times even encourage them. Such findings suggest that although from a western perspective, one is inclined to treat extramarital affairs, or polygamous marriages, as indicative of relationship troubles and moreover women's suffering, this is potentially in conflict with the orientations and constructions of people themselves. [39]

[39] Whether or not it is an accurate representation of women's feelings, I cannot say, as this falls outside the remit of my discourse analytic framework.

Third, there is a discrepancy between my finding that respondents do not complain about others, or construct others as not to blame for relationship troubles, and the literature, in which men and especially women with fertility problems are portrayed as the victims of social exclusion, accusations, stigmatisation and abuse, inflicted upon them by others, who are thus to blame for the hardship caused. Again, a close inspection of the findings which authors report suggest that in other studies, the responses of some participants fulfil a similar function of not blaming. For instance, Dyer et al. (2004) mention that some respondents said that relatives might be unaware of the impact of their comments, and that some informants said they themselves tried to avoid social contacts. 'Not blaming' seems to be going on in Riessman's (2000) study as well. Riessman (2000, p. 118) cites descriptions by respondents of what she calls 'discrediting encounters' with others. Many of these come across as objective and neutral, in part due to the use of reported speech and absence of assessments, as is the case in extracts shown in this chapter. In addition, Riessman reports the following exchange between a respondent and herself:

> 'Neighbours, every time they ask….In Mayalam they ask, you know, 'Vishesham' [any special news]? Every time.' *When I inquired, 'is it an insulting term?' She responded, "No not that'* and then explained it is 'colloquial language', a way that others ask about pregnancy right after marriage. After 11 years of marriage, she finds persistent questioning 'awkward' and then *she agreed with my earlier formulation: 'You feel insulted'*. (Riessman, 2000, p. 119, italics added)

In denying it is an insulting term, and explaining that it is 'colloquial language', the respondent appears to resist blaming others, which Riessman's (2000) paraphrase 'You feel insulted' glosses over. As is normally the case in qualitative studies of infertility, Riessman tries to bring out the respondent's feelings, presumably with the aim of showing the discrediting nature of the respondent's encounters. However, in so doing, she loses sight of the actions in which the respondent engages in her account.

Overall, the discrepancies can be taken to suggest that although authors' glosses may fulfil a laudable political function of giving voice to infertile men and especially women's suffering, they may not be in line with people's own

constructions of relationships and relationship troubles (cf. Widdicombe, 1995). This has practical implications for attempts to address relationship troubles of people with a fertility problem, as one will have to work with people's own constructions of troubles and the concerns they themselves thereby attend to. These may include moral concerns related to problems involved in complaining about or blaming others for relationship troubles.

Note that I do not intend to dismiss the problems encountered by people with a fertility problem. On the contrary, it would seem that the discursive practices which I have discussed, not complaining about, and not blaming others for relationship troubles, contribute to the quandary in which people with a fertility problem find themselves in; it takes away possibilities of 'speaking out' and 'acting up' (cf. Riessman, 2000). I will discuss further these practical implications in chapter 10.

So far, I have mainly focussed on the interpersonal, normative, and moral issues which people who are faced with a fertility problem, or their significant others, deal with. In the next two chapters, I will shift the focus to indigenous and biomedical practitioners.

Chapter 8. Issues of accountability and identity in professionals' talk about causes

Some studies have drawn attention to the social nature of practitioners' views, knowledge, and practices in relation to infertility (see chapter 2, section 2.4). They have shown how medical practices are informed by certain interests, rather than being merely objective scientific 'facts'. For instance, Inhorn (1998) argues that Egyptian physicians are keen to perform invasive technical procedures, which are of doubtful benefit, because it is an important source of income. In addition, she suggests that physicians' limited disclosure of information to infertility patients, for instance regarding diagnoses, serves the interest of maintaining professional boundaries. Furthermore, scholars have pointed to the normative basis and moral consequences of physicians' diagnoses, such as how certain diagnoses make patients to blame for their own infertility (Pfeffer, 1993; Sandelowski, 1990). Moreover, it has been argued that the provision of treatment depends on physicians' moral categorisations of patients as more or less appropriate for treatment, based on for instance diagnoses (Pfeffer, 1993) or other features such as lifestyle or socio-economic class (Malin, 2003; Steinberg, 1997). Cultural aspects of practitioners' views and practices regarding infertility have been addressed as well. Oyebola (1981) for instance, in his study on indigenous healers in Nigeria, examines the healers' knowledge of causes of infertility and their treatment. He concludes that these are 'based on superstitions' and 'lack scientific basis' (Oyebola, 1981, p. 785). Hence, Oyebola (1981) seems to be suggesting that their knowledge and practices are based on culturally specific beliefs, rather than universally valid, scientific 'facts'.

In general, since the 1970s and 1980s, scholars have called for an acknowledgement of the social, cultural, and thus constructed, nature of medical practices and knowledge (Foucault, 1973; Hahn & Kleinman, 1983; Lock & Gordon, 1988; Wright & Treacher, 1982). Hence, scholars, especially medical sociologists, have argued that lay and experts' knowledge should be treated as on a par, rather than attributing a special 'immaculate' and objective quality to scientific, biomedical knowledge (Arksey, 1948; Prior, 2003; Sarangi, 2001). Medical sociologists have

focused in particular on the social nature of medical knowledge concerning disease categories and causes of illnesses, and of diagnostic practices. They have shown that these types of medical knowledge and practices are not 'natural' and self-evident but social products, created in social activities and contingent upon the societies in which they are used (Nettleton, 1995). For instance, Lupton (1994, p.55) discusses how 'identifying' symptoms is a socio-cultural act and construction process, in that novice clinicians are trained in, or acculturated into 'ways of seeing in the clinic'. Furthermore, as in infertility studies, medical sociologists have pointed out how in general, illness and diagnoses are intertwined with moral judgments of responsibility and blame (Lock & Gordon, 1988; Lupton, 1994).

It appears that work done so far on the social dimensions of medical knowledge and practices in the developing world, regarding infertility but also more generally, could be expanded. This is first of all because most studies which discuss the social aspects of *biomedical* practitioners' views and practices focus on the west (van der Geest & Finkler, 2004; Lock & Gordon, 1988). Regarding infertility, more recently studies have examined assisted reproductive technologies (ART) in developing countries (Inhorn, 1994, 2002; Bharadwaj, 2002; Handwerker, 2002). However, these technologies are only available in a limited number of African countries, and are absent in Malawi. Hence, studies of ART leave out the majority of medical practices.

As Lock (1988) points out, scholars' limited attention to biomedicine in developing countries contrasts sharply with a strong interest in, and a wealth of studies on, indigenous healers' knowledge, beliefs, and practices regarding various health issues (see for instance Chipfakacha, 1997; Courthright, 1995; Dagher & Ross, 2004). It appears therefore, that many scholars still treat biomedicine, unlike traditional healing, as an a-social, universal framework of practice, based on objective scientific rationales and requiring neither examination, nor explanation (van der Geest & Finkler , 2004; Lock, 1988; Ogden, 2002).

Second, overall, studies of bio- or indigenous medicine in the developing world tend to treat medical practices and knowledge as formed by, and representing, the 'macro' cultural context. For instance, Finkler (2004, p.2048) concludes in her study of physicians in Mexico that 'medical practices in any society replicate the

world in which they are embedded and open a window into the society and culture of which they form a part'. Certainly indigenous healers' views and practices are commonly seen and displayed as ingrained in the local cultural context (cf. Lock, 1988). For instance, in many studies, the cultural specificity of healers' knowledge and practices is underlined by comparing them with biomedical notions and practices. In addition, authors emphasize the cultural acceptability of healers' care (Chipfakacha, 1997; Courthright, 1995; Dagher & Ross, 2004). Furthermore, the cultural nature of indigenous healers and their treatment is sometimes built into their definition. For example, Oyebula (1986, p.222) defines a healer as 'someone who is *recognized by the community* in which he lives as competent to provide health care by using (…) methods *based on the social, cultural and religious backgrounds* as well as the prevailing knowledge, attitudes and beliefs (…) *in the community*' (italics added). However, a growing body of conversation analytic studies of doctor-patient interactions in the west has shown how the more local, 'micro', interactional context also informs the construction of professionals' views and practices (Frankel, 1984; Heritage & Maynard, 2005; Silverman, 1987; West, 1984). For instance, Peräkylä (1998) shows how doctors attend to their accountability for their diagnoses, especially when their expertise appears challenged. Pomerantz, Fehr and Ende (1997) have shown how supervisors correct interns' errors in ways which avoid exposure of the error. It thus appears that insight into the social nature of practitioners' views and practices in developing countries could be increased by examining their interactional and interpersonal functions, rather than restricting analysis to the culturally specific content of beliefs and practices.

In chapter 5, I have shown how 'illness attributions' by people with a fertility problem, and significant others, can be usefully treated as constructions which fulfil certain interactional and interpersonal functions. In this chapter, I will examine indigenous and biomedical practitioners' responses to questions about causes of infertility. In the initial stages of the analysis, I was struck by the work which practitioners appear to do to make their claims persuasive. I therefore examined practitioners' persuasive design in more detail, which made apparent that practitioners attend their professional accountability and identity in their claims. Hence, in this chapter I will show how indigenous *and* biomedical practitioners'

constructions of causes also appear to deal with interpersonal and interactional issues.

8.1 Making claims persuasive

In my interviews, I asked practitioners what they considered to be the main causes of infertility, in the patients they see or in Malawi in general. Extracts 1 to 3 are examples of responses to this question.

Extract 8:1 Int. 36 2HSAs ((Rf = female respondent Rm =male respondent))

518. I Yah. An- any other reasons why people can fail to bear children?
519. Rm Abortions.
520. I Abortions.
521. Rm (hm:)
522. I Uhu, how [does that happen?
523. Rf [·hh Because of several abortions, that's why some are barren.
524. I Okay
525. Rf Because if they have taken eh: strong drugs,
526. I Uhu
527. Rf that is strong- the drugs go to: eh uterus.
528. I Uhu
529. Rf So: that uterus can eh come to pieces,
530. I Uhu
531. Rf yah, that's why they are barren.

Extract 8:2 Int. 16 m.d, expat.

579. I Okay, ehm, what are the main causes of the infertility patients you've seen.
580. R Well the two most common ones are myomas and HIV.
581. I Okay, yah. And
582. R Sexually transmitted diseases is number three because I mean that's still
583. very common here and it causes adhesions that tubes get closed, and
584. that's why people can't ( ). I think that are the main three.
585. I Yah, okay and then I mean the myoma's that of course only for the
586. women ehm, is there HIV and sexually transmitted diseases is that (both) in
587. men and women or
588. R Yah. Well I'm not sure I I haven't read say recent scientific articles, but in
589. men it's just known that if they got eh well any kind of disease even a simple
590. flu, it reduces the fertility straight away.
591. I yah
592. R temporarily. And HIV so far cannot be cured, so, I'm not sure if it has ever
593. been written down, but it's, it can't be it it must be the case that when a
594. husband, when a man is HIV positive in a bit of an advanced stadium that he
595. has reduced fertility
596. I yah
597. R And we have got the impression, it's the same in women. Because I'm su-
598. I've we've I've got the impression. That if you would test all women that are
599. HIV negative, that are that are infertile you would get a higher percentage of
600. HIV positivity than the women in general.
601. I Yah, yah
602. R But that's just my impression, I've never calculated that.

Extract 8:3 Int. 7 m.d, expat. ((in response to the question 'what are the main causes from your perspective in the infertility patients you see', the respondent mentioned several causes, amongst others that 'sometimes you find a very low sperm count in the man'))

389. I And ehm, low sperm count is there any underlying reason behind that or
390. R Yeah many, hhuhu, also, it can be more or less congenital thing, ehm eh
391. basically something they've always had. It can also be caused by
392. infection ehm, what you can sometimes see here for instance. I don't
393. know if this causes low sperm count but I have sometimes seen
394. testicular TB eh yeah which obviously (destructs) the the test destroys
395. the testes ehm but then we didn't even do a sperm count I think but
396. ehm.
397. I yah
398. R yah and you see all the same things as in ((name home country)) he that you
399. can never test here, but which you can suspect , people changing partners and
400. then there's the there's the, there's the, mechanism where eh where eh there
401. are antibodies formed against sperm.
402. I hmhm okay.
403. R Ehm and-you often see that when there's a change of partner. Ehm yah
404. you also sometimes see that here as well, husband has children, wife
405. children, they come together, as new partners and they can't get children
406. and yeah that suggests that something like that might playing a role, but.
407. (.) Obviously there's no laboratory or anything in Malawi that can test
408. that.
409. I no, so that's a bit- of a guess then.
410. R yeah
411. I Yah
412. R Yeah

In extracts 1 and 2, respondents are asked what the main causes of infertility are. In response, they identify abortions (extract 1, line 519), myomas, HIV and sexually transmitted diseases (extract 2, lines 580-582). The respondent in extract 3 was asked about the main causes of infertility just before the extract. One of the causes which he mentioned was 'a very low sperm count'.

In all these extracts, the interviewer probes for the respondents' identification of causes. As I will show, the interviewer's probes form a mild challenge to the veracity of the respondents' claims. In extract 1, the interviewer asks 'how does that happen', (line 522), in extract 3 whether there is 'any underlying reason behind low sperm count' (line 389). These probes constitute a request for clarification regarding the mechanisms through which the proposed cause leads to infertility. They can therefore be seen as indicating that the interviewer does not understand why, or is not convinced that, the proposed causes lead to infertility. In extract 2, the interviewer qualifies the proposed cause of myomas as holding true 'of course only for the women' (line 585-586). She then asks whether HIV goes for both men and women

(line 586 to 587). Hence, the interviewer's probe suggests that she is not convinced that HIV is a relevant cause for both men and women.

In their responses to the interviewer's probe, respondents indeed identify a mechanism through which the proposed cause leads to infertility. In extract 1, the female respondent explains that 'several abortions' (line 523) can lead to infertility because 'if they have taken eh: strong drugs' (line 525), these go to the uterus (line 527), which can 'come to pieces' (line 529). In extract 2, the respondent explains why HIV is a cause of infertility in both men and women: in men, 'any kind of disease' reduces fertility (line 589-590) and 'we have got the impression, it's the same in women (line 597). In extract 3, the respondent proposes several mechanisms for how someone can get a low sperm count: 'it can be more or less (a) congenital thing' (line 390), 'it can also be caused by infection' (line 391-392), for instance by 'testicular TB' 'which obviously (destructs) the the test destroys the testes' (line 394-395). In addition, the respondent points out that when people change partners, 'there's the mechanism where eh where eh there are antibodies formed against sperm' (line 400-401).

Several interesting observations can be made regarding the way in which respondents respond to the interviewer's probe and explain the mechanism underlying the proposed causes. First, respondents construct the relation between the proposed cause and infertility as strong and certain. They do so especially by means of (implicit) if-then constructions, which, as Edwards and Potter (1992) have noted, can be used to establish logical and thus firm and inevitable connections. In extract 1, the respondent mentions '*if* they have taken eh: strong drugs' (line 525), '*So:* [then] that uterus can eh come to pieces' (line 529). In extract 3, the respondent states that '*if* they got eh well any kind of disease (…) [then] it reduces the (in)fertility straight away' (line 590) and '*when* a man is HIV positive (…) that [then] he as reduced fertility'(line 594). In addition, the respondent in extract 3 brings out the necessary connection between HIV and reduced fertility also by stating that this '*must* be the case' (line 593). Furthermore, he attends to a strong connection to diseases and infertility by saying that they reduce fertility 'straight away' (line 590).

Second, by using the strong expressions 'come to pieces' (extract 1, line 529) and 'destroys' (extract 2, line 394), respondents underline the devastating power of

respectively abortions and testicular TB, and make it convincing that they corrupt the organs necessary for reproduction, namely the uterus (extract 1, line 529), and testes (extract 3, line 394).

Third, the respondents attend to their claims as common knowledge. In extract 2, the respondent does this when he claims that 'it is just known' (line 589) that diseases reduce fertility, in extract 3 when he claims that testicular TB 'obviously' (line 394) destroys the testes. By means of these appeals to common, taken for granted knowledge, respondents attend to and forestall sceptical reactions regarding their claims.

Fourth, in extract 3, the respondent makes his claim regarding HIV as a cause of infertility persuasive by pointing out that 'any disease, even a simple flu' (line 589) can reduce fertility in men. This makes it conceivable that HIV leads to infertility, as it is a recognizably more serious disease than flu; HIV, certainly when 'in a bit of an advanced stadium' (line 594) it is not just 'any disease'. Note that presumably, the respondent uses mistakenly the word 'stadium' instead of 'stage'. The respondent constructs a contrast between HIV and flu by classifying flu as 'simple' (line 5989) and HIV as an illness which 'so far cannot be cured' (line 592). By making it convincing that HIV leads to reduced fertility in men, the respondent makes his 'impression' (line 589, 598) that women with HIV will have a reduced fertility as well more warranted.

Fifth, the respondent in extract 3 refers to empirical observations, which makes his claims regarding causes of infertility convincing. The respondent describes testicular TB as something 'what you can sometimes see here' (line 392) and as what he has seen himself: 'I have sometimes seen testicular TB' (line 393). The respondent portrays also partner change (line 398, 403, 405), leading to the formation of antibodies (line 401) as based on observations: 'you see all the same things as in ((name home country)) (line 398), 'and- you often see that' (line 403) and 'you also sometimes see that here as well' (line 404). As Pomerantz (1984) points out, direct experiences, and thus observations, are an important resource for establishing the certainty of a state of affairs. Peräkylä (1998) found as well that Finnish doctors account for their diagnoses by using verbs which construct them as based on empirical observations, such as 'it *feels* normal'. In addition, she notes that the

physicians make relevant such sensory evidence especially when their expertise appears challenged (op cit.), as appears to be the case in extract 3.

Hence, I have shown several ways in which respondents make their claims persuasive. However, respondents can also be seen to attend to their claims as tentative, for instance in the aforementioned reference to an 'impression' that women with HIV have a reduced fertility (extract 2). In the next section, I will examine such instances in more detail.

8.2 Attending to the basis of knowledge claims: 'Doing being medical expert'

In extracts 2 and 3, as well as in extracts 4 and 5, displayed below, respondents can be seen to characterise their knowledge as uncertain.

Extract 8:4 Int. 7 m.d, expat.

323. I Ehm what are the main causes from your perspective in the infertility
324. patients you see.
325. R Ehm: (.5) well I would think, well yah that that's also difficult to answer
326. because I would like to answer that exact and I don't know , ehm because
327. the main causes we find here are either infection eh
328. I Hmhm
329. R or eh yah you get sometimes women with large fibroids or whatever,
330. I Hmhm
331. R which can be a cause you also don't know for sure but.
((some lines omitted))
353. R Yah, yah then it's mostly STDs and (.) apparently bilharzia but so I find
354. bilharzia sometimes, and then I treat it but I don't I have not yet seen it that
355. it then helps.
356. I Yah
357. R Ehm but yeah that's just what I've read and
358. I Yah
359. R Hhu hu yah.
360. I Yah you can, always give it a try hhaha ( )

Extract 8:5 Int. 43 nurse ((respondent has mentioned before some causes of infertility when talking about her sister, whose husband had sexually transmitted infections, and a couple who were failing to conceive because they were very young))

870. I Ehm can you mention any other causes which are quite common in the
871. patients that you see here?
872. R In the patients I see. Ehm I haven't the (correct) details. I don't know what is
873. the cause of low motility.
874. I hm
875. R Could it be the infection itself of course. Infection itself.

I would like to note first of all that in extracts 2 to 5, the respondents attend to the basis of their claims about causes. More specifically, as I will show, they make clear

that the basis of their claims is uncertain. They do this to begin with by making clear that they lack certain information. In extract 4, the respondent states at the start of his response to the interviewer's question about causes 'that's also difficult to answer' (line 325), and explains that this is so because 'I would like to answer that exact and I don't know' (extract 4, line 326). Hence, the respondent implies that he lacks certain 'exact' details to base his claims on. Likewise, the respondent in extract 5 states 'I haven't the (correct) details' (line 872), and 'I don't know what is the cause of low motility' (line 872). The respondents in extracts 2, 3, and 4 also point at a lack of information, of a particular kind. In extract 4, the respondent makes clear that his claims are not based on personal observations. He states '*apparently* bilharzia' (line 354), thereby implying that his claim regarding bilharzia as cause of infertility is not based on his own experience. He makes this explicit when he points out that when he treats people for bilharzia, 'I don't I have not yet seen it that it then helps' (line 354-355), and by pointing out that his claim is based on ' what I've read' (line 357). By pointing to the lack of personal observations, the respondent constructs the basis of his claim as (relatively) tentative. In extracts 2 and 3, the respondents point at the absence of (quantative) empirical proof, namely calculations and test results. The respondent in extract 2 states 'I've never calculated that' (line 602). The respondent in extract 3 makes clear that they did not do a sperm count (line 395), and that whether a change in partner results in antibodies against the sperm (line 399) is something which 'you can never test here' (line 399), as 'obviously there's no laboratory or anything in Malawi that can test that' (line 407-408). Furthermore, the respondent in extract 2 states 'I haven't read say recent scientific articles' (line 588) and 'I'm not sure if it has ever been written down' (line 644). By pointing out that his claim, in this case about the role of HIV in infertility, is not based on an authorative source, such as scientific publications, the respondent attends to the basis of his claim as (more) tentative.

Noteworthy is the use of the word 'just' in the extracts 2 and 4: 'but that's just my impression' (extract 2, line 602) and 'but yeah that's just what I've read' (extract 4, line 357). 'Just' appears to be used in a depreciatory sense (Lee, 1984), in which it plays down the relevance of one situation in comparison to another. In extract 3, 'just' can be seen to play down the value of impressions with respect to

calculations, in extract 4, the value of reading about a cause in comparison to making observations about it yourself. As a result, 'just' plays down the force of respondents' claims, and supports respondents' orientation to the basis of their claims as tentative.

Respondents' orientation to the absence of a firm basis for their knowledge, implies that they are uncertain about their claims. Indeed, respondents make this explicit in several ways. First of all, they use expressions which convey a notion of uncertainty. In extracts 2 and 4, the respondents state explicitly that they are uncertain with respect to their claims about respectively HIV and fibroids as causes of infertility: 'well I'm not sure' (extract 2, line 588), and 'you also don't know for sure' (extract 4, line 331). Note that the word 'also' (line 331), implies that the respondent's previous claim, that infections can cause infertility (line 327), is tentative as well; 'also' implies an equality in uncertainty regarding the two causes. In addition, in extract 2, the respondent conveys a notion of uncertainty when he states 'we have got the impression' (line 597). Note the repair of 'I'm su-' into 'I've got the impression' (lines 597-598). As 'I'm su-'can be assumed to be the start of 'I'm sure', the respondent here construes himself as less certain than 'sure'. His repair of 'we've' into 'I've' (line 597) constructs the 'impression' as more personal, and thus less certain. In extract 3, the respondent states that antibodies being formed as a result of partner change is something which 'you can suspect' (line 399) and which is suggested (line 406). Both terms frame the respondent's state of knowledge as indefinite, as does the identification of factors as something which 'might be' (extract 3, line 406) or '*can* (also) be' a cause (extract 3, line 390, 391; extract 4, line 331). Furthermore, in extract 4, by saying 'I would think' (line 325) the respondent constructs his claims regarding causes as a personal opinion, and thus less certain, an established fact (Latour & Woolgar, 1986). Moreover, in extract 5, the respondent makes her suggestion tentative by using the format of a question to propose infection as cause of low motility: 'could it be the infection itself' (line 875).

In extracts 3 and 4, the interviewer picks up and attends to the uncertainty displayed in the responses. In extract 3, she provides the upshot 'so that's a bit- of a guess then' (line 409). In extract 4, she states 'you can always give it a try' (line

360). Thereby she can be seen to attend to treating bilharzia as a potential but uncertain solution for a fertility problem, and thus to bilharzia as uncertain cause.

Both the persuasive and tentative design of claims regarding causes appears to tie in with identity issues which the respondents attend to. I have shown that respondents make clear that their claims about causes of infertility are not informed by empirical observations (extract 4, lines 353, 354), by performing calculations (extract 2, line 602), counts (extract 3, line 395) or tests (extract 2, line 598; extract 3, lines 399, 407). In addition, in extract 2 the respondent points out that his claim is not based on his reading scientific papers, the respondent in extract 4 makes clear that his claim is *only* based on the literature which he read (extract 4, line 357).

These are all activities which are recognizable as category bound activities (CBAs, Sacks, 1992; Watson & Weinberg, 1982) of biomedical experts. CBAs are activities which, according to common sense, are associated with certain identity categories. For instance, mothers are expected to pick up babies when they cry and soothe them. Likewise, biomedical experts are expected to perform calculations and tests, and read scientific literature. Sacks (1972, 1992) has pointed out that due to the association between CBAs and identity categories, CBAs are 'inference rich'; by describing a CBA, a speaker can evoke an identity category. In most of the extracts displayed above respondents make clear that they have *not* performed certain activities, they have for instance *not* tested and calculated their claims about causes. Nevertheless, the respondents attend to these activities as relevant, and thereby orient to their, in principle, desirability. Therefore, it can be argued that by referring to activities like making observations, testing, counting calculating and reading scientific literature, the respondents invoke the identity category 'biomedical expert'.

Having correct knowledge about causes of diseases can be seen to be another CBA of biomedical experts (cf. Gill, 1998; cf. Maynard, 1991). Therefore, whilst people are in general accountable for portraying a state of affairs correctly when making declarative, factual statements (Pomerantz, 1984), this is all the more so for biomedical practitioners who make claims about causes of health problems, like infertility. Hence, such claims can place one's identity of biomedical expert at risk, if they are doubted or challenged. As mentioned in section 8.1, in various extracts, the interviewer's probes can be seen as constituting a challenge, and in principle this

always remains a possibility when knowledge claims are made. Therefore, both constructing one's claims as factual and convincing, and attending to their tentative basis, appears to fit in with respondents' orientation to their identity of biomedical expert. On the one hand, making one's claims factual and convincing can be seen to be an 'offensive' strategy to protect one's expert identity from scepticism. On the other hand, constructing the basis of one's knowledge claims as uncertain is a more defensive strategy. It is a form of 'hedging', one of the types of 'disclaimers' described by Hewitt and Stokes (1975), as discursive devices which define forthcoming claims as not relevant to (negative) typifications which they would normally form a basis for. Examples of hedging, as discussed by these authors, are 'I'm no expert of course, but…' and 'I could be wrong on my facts, but I think' (Hewitt & Stokes, 1975, p. 4). According to Hewitt and Stokes (1975), 'hedging' wards off negative identity attributions by signalling minimal commitment to a claim. It can be argued then, that in the extracts discussed, respondents display a minimal commitment to the truth status of their claims by 'hedging', that is, by constructing their claims as tentative. Thereby they forestall that (potential) challenges regarding their claims put their identity of biomedical expert at risk.

8.3 Indigenous healers defending their expertise

So far, I have focussed on biomedical practitioners' constructions. As I will show, indigenous healers also appear to construct their claims as persuasive in the light of challenges. Consider extract 6

Extract 8: 6 Int. 60 pilot ind.h[40]

274.I	And what about I heard people say	
275.	here in Malawi as well that it can be	
276.	due to witchcraft that people cannot	
277.	get a child. What do you think	
278.	about that?	
279. T		*She says I have heard that people can bewitch*
280.		*each other so that someone should not be able to*
281.		*give birth. What do you know about this?*
282. R		*Huhu. A::h! It happens.*

[40] Transliteration of Chitumbuka is not available; as translations are expensive I could only afford a limited number of translations.

283. T *It happens?*
284. R *It really happens.*
285. T *↑Okay.*
286. R *They pick her up in the spirit[41] and tie her at the*
287. *back to make the eggs invisible.*
288. T *↑Okay*
289. R *Yaah! Sometimes they can even tie the*
290. *pregnancy like that. A baby can be in the womb*
291. *for 2 years like this woman sleeping here they*
292. *chased her from the hospital because they*
293. *thought she was not pregnant but she is*
294. *pregnant.*

((some lines omitted in which the respondent claims, amongst other issues, that people can remain pregnant for 5 years))

298.T She says yes, there is that (you
299. can really) she says it's true, (that)
300. at times the (.) the witchcraft
301. happens.( )Sometimes the
302. woman cannot even have a (oil) of
303. the [(ovum/ova)]
304.R [ ]
305.T that there could be infertility. (And
306. even) there couldn't be fertilisation
307. of the ova. And at times you will
308. find that eh wo- a pregnant woman
309. stays five years without delivery.
310. And the: people at the hospitals may
311. say she's not pregnant and yet she is
312. pregnant.
313. I O:kay=
314. T =That's what's she (is saying)

Asked what she knows about 'people who can bewitch each other so that someone should not be able to give birth' (line 281), the respondent points out that this happens: 'A::h! It happens' (line 282). The interpreter subsequently probes 'it happens?' (line 238). This can be seen as a display of surprise, and of potential scepticism regarding the respondent's claim. As seen before, the respondent makes her claim that witchcraft leads to infertility convincing in response to this mild challenge. She does this in several ways. First of all, she confirms that 'it really happens' (line 284). By 'really', the respondent emphasizes the truth of her claim.

Second, the respondent subsequently provides more detailed information about how someone can become bewitched: 'they pick her up in the spirit and tie her at the back to make the eggs invisible' (line 286-287). As Edwards and Potter (1992) have argued, detailed accounting, or 'vivid description' can make claims come across as factual and hence persuasive. In this case, this is also because the details point at a

[41] Translator indicated that 'spirit' can be translated as 'magic' as well.

mechanism by means of which witchcraft can lead to infertility; 'tying' someone at the back so that eggs become invisible. Explaining the mechanism through which a proposed cause leads to infertility is a method of making the claim regarding the cause convincing. Third, the respondent gives an empirical example of a witchcraft induced fertility problem: 'A baby can be in the womb for 2 years' (line 290-291), 'like this woman sleeping here' (line 291). She provides empirical proof, which supports her claims regarding witchcraft as cause of fertility problems, in particular, remaining pregnant for a number of years. The interpreter also makes relevant empirical observations which sustain the respondent's claim: 'at times you will find' (line 307-308). Fourth, the respondent attends to, and rejects a sceptical response regarding her claim that the woman is pregnant. She describes how 'they chased her away from the hospital because they thought she was not pregnant' (line 291-294). By pointing out that they *thought* she was not pregnant, she constructs this as a personal opinion rather than a fact (Latour & Woolgar, 1986). In addition, she contrasts the hospital's opinion, by means of the contrast marker 'but', with a factual state of affairs: 'she is pregnant' (line 293-294). Furthermore, the interpreter makes clear that sceptic reactions are refuted by constructing them as something what people 'may say' (line 310-311), and contrasting this by means of 'and yet' with a factual state of affairs: 'she is pregnant' (line 311-312).

Note that the respondent's construction of her claims as persuasive and convincing can be seen as informed also by the interpreter's turns in lines 285 and 288. The heightened intonation in '↑Okay' (lines 285 and 288) can be seen to indicate surprise, and therefore occasions the inference that the interpreter may not be convinced by the respondent's claims.

In extract 7 below, a traditional healer defends her knowledge about causes when faced with a potential challenge as well

Extract 8: 7[42] Int. 38 ind.h

477.I And you told me, some things now
478. what you think the causes are of
479. this failure to bear children. What
480. do your patients think is the cause of
481. their problem?
482. T *She says when these patients come and you have*

[42] For practical reasons, transliteration of Chichewa is not available (see footnote 40)

483.	*told them, do others speak out their views*
484.	*regarding what they feel is the problem?*
485. R	*That the problem is ( )?*
486. T	*Or perhaps you have told them they have a*
487.	*disease but they are saying their grandparents*
488.	*might have bewitched them. She wants to know*
489.	*whether such things happen.*
490.R	*I refute that, I tell them they are liars (.) Its not*
491.	*possible to cast a spell inside the abdomen so*
492.	*that someone should be infertile, no. She can go*
493.	*to the witchdoctors and they can tell her that*
494.	*maybe it's your mother-in-law or father-in-law*
495.	*or your grandmother but it may not be true. But*
496.	*here (I) am able to know the real cause why she*
497.	*is not able to have children. I tell her the problem*
498.	*I have found with you is this this.*

The interviewer asks the healer what her patients think is the cause of their fertility problem (line 478). After his first translation, the interpreter rephrases his question and makes relevant a potential difference in opinion between patients and the healer regarding the cause of the fertility problem: 'perhaps you have told them they have a disease but they are saying their grandparents might have bewitched them' (line 486-489). This hypothetical situation implies that the veracity of the respondent's knowledge claims is challenged. In her response, the respondent inoculates this challenge. She does this first of all by rejecting the hypothetical, alternative cause, by stating 'I refute that' (line 490), and also by constructing it as a lie: 'I tell them they are liars' (line 490), and as impossible: 'it is not possible to cast a spell inside the abdomen.'(line 490-491). Second, the respondent attends to, *and* discards, a source which supports patients' ideas that they may have been bewitched: 'the witchdoctors (…) can tell her that maybe it's your mother-in-law or father-in-law or grandmother, but it may not be true' (line 495). Third, the respondent points to her capacity to know the truth about causes of infertility: 'But here (I) am able to know the real cause why she is not able to have children.' (line 495-497). Fourth, the respondent states 'the problem I have found' (line 497-498). 'Found' implies that the respondent is able to make empirical observations, which form supportive evidence for her capacity of knowing the facts about causes of infertility, whether in particular cases or in general.

Thus, it appears that, like biomedical practitioners, indigenous healers also deal with and inoculate mild challenges regarding the veracity of their claims, by

making them persuasive and rejecting alterntaive explanations. It is to be expected that for indigenous healers too, knowing about causes is a category bound attribute, making challenges to the veracity of their claims regarding causes a threat to their identity of illness expert.

8.4 Sensitivities in biomedical practitioners' talk about non-biomedical causes

I have shown two extracts in which indigenous healers discuss the possibility of witchcraft as cause of infertility. Biomedical practitioners too address such non-biomedical causes, although normally only when asked about them. As I will demonstrate in this section, examination of the way in which biomedical practitioners talk about non-biomedical causes points to certain additional interpersonal and interactional issues for biomedical practitioners.

8.4.1. Sensitivities related to respondents' biomedical expert identity

One issue, which respondents appear to deal with when addressing non-biomedical causes of infertility, is related to their biomedical expert identity. Consider extracts 8 and 9.

Extract 8:8 Int. 37 nurse

611. I Okay. And what about for example, possession by ancestral spirits or
612. witchcraft, do you think that plays a role as well in in infertility?
613. R No, I don't think I believe in those. No.
614. I In in neither or
615. R I don't believe one could not produce a child because the spirits have held one,
616. no I don't believe in those. Because after my nursing training, after learning
617. about the biology of the reproductive system,
618. I Uhu
619. R I don't believe any person can hold another into child bearing, it's only God,
620. not a human being.

((some lines omitted))

626. R But maybe abortions, if someone was having pregnancies and aborting,
627. I Uhu
628. R some people believe witchcraft people can remove pregnancies from
629. someone.
630. I Uhu. Yah. I see.
631. R Uh
632. I And- what do you think about that?
633. R ↑A:h I really don't know, I don't knowhhuhu.

Extract 8: 9 Int.58 c.o

183. I Yeah I see hm. And e:hm I sp- I heard some people also say that eh

witchcraft might be a cause of the infertility. What do you think
about that?
R Hmhahahehe eh (.) you know we are people of sciences, there's no
witchcraft <u>but</u>.
I Hm
R ↑ It can (work) maybe but eh witchcraft don't (cause infertile)
hahaha > what do you think<?

Several features of the responses in the extracts above, suggest that addressing non-biomedical causes is in some way problematic for the respondents.

First, the responses are ambiguous. Both respondents start off denying belief in the reality of non-biomedical causes: 'No I don't think I believe in those' (extract 8, lines 613, 615, 616, 619) and 'there's no witchcraft' (extract 9, line 186-187). However, after the denials, the respondents appear to make a concession regarding the reality of non-biomedical causes. In extract 8, the respondent states 'but maybe abortions' (line 626), and appears to imply that abortions may be caused by witchcraft. In extract 9, the respondent states '<u>but</u> (..) ↑it can (work) maybe' (line 189). 'It' can be assumed to refer to witchcraft. This makes the responses ambiguous, especially in extract 9, where the respondent subsequently backtracks his concession: 'but eh witchcraft don't (cause infertile)' (line 189).

Second, the denials, and especially the concessions regarding the reality of witchcraft, come across as non-committal. This is so to begin with because respondents construct their responses as uncertain, by means of expressions like 'I don't think' (extract 8, line 613, cf. Latour & Woolgar, 1986) and 'maybe' (extract 9, line 626, extract 9, line 189). In addition, in extract 8, the respondent only implicitly suggests that 'maybe abortions' (line 626) can be caused by witchcraft . Furthermore, her concession appears non committal because she frames it as *other* people's belief, rather than her own: 'some people believe witchcraft people can remove pregnancies from someone' (lines 628-629).

In so doing, the respondent can be seen to avoid expressing her own opinion. She does this as well in response to the interviewer's probe, 'what do you think about that?': 'A:h I really don't know, I don't know' (line 633). In extract 9, the respondent avoids providing his opinion by asking for the interviewer's: >'what do you think?< (line 190). Withholding a personal opinion is a third feature which suggests that addressing non-biomedical causes is problematic for the respondents.

Fourth, when the respondent in extract 9 asks for the interviewer's opinion and thus attends to this as relevant (line 190), he can be seen to take into account potential (negative) judgements, which suggests as well that non-biomedical causes is a sensitive topic.

Fifth, the respondent in extract 9 starts his response with laughter, which as Jefferson (1984) and Hakaana (2002) have found, commonly accompanies talk about topics which are, for some reason, troublesome.

Sixth, the respondents treat their disbelief and rejection of the reality of witchcraft as accountable (extract 8, lines 616-619, extract 9, line 186). Thereby they attend to it as at best not self-evident, at worst dispreferred. Both respondents make relevant a biomedical, or scientific, expert identity in their accounts. The respondent in extract 9 does this explicitly, by stating 'we are people of sciences' (line 186). In extract 8, the respondent makes relevant category attributes (Sacks, 1992) associated with the membership category of biomedical expert, namely having received 'nursing training' (line 616) and having learnt 'about the biology of the reproductive system' (line 616-617). In so doing, she evokes an identity of biomedical expert. By attending to a biomedical, scientific expert identity in their accounts for disbelief, the respondents attend to believing in the reality of supernatural causes as irreconcilable with being a 'trained nurse' or 'people of science'. This suggests that claims regarding non-biomedical causes can form a threat for respondent's identity of biomedical expert. Denying belief in witchcraft, or providing ambiguous, non committal responses in terms of other people's beliefs, can be seen as ways in which the respondents deal with and inoculate this threat.

It is noteworthy however, that the respondents do not straightforwardly reject the idea that witchcraft can lead to infertility; there is some ambiguity in their responses, which I will address in the next section.

8.4.2 Not dismissing non-biomedical causes

I have mentioned how the respondent of extract 9 makes relevant other people's beliefs in non-biomedical causes. Other respondents do this as well. Consider extracts 10 to 12.

Extract 8:10 Int. 8 m.a

354. I Okay I see hmhm. Ehm, are there also any more spiritual or traditional reasons
355. why (.) your patients can become infertile.
356. R Yah other, I don't know again call it whether spiritual or [whatsoever.
357. I [Hm:
358. R Most of them they just say ah maybe, my wife has been bewitched.
359. I Uhu.
360. R You are telling me that, she is able to produce, everything is is quite alright
361. and I'm alright and we're not producing, ·h maybe we have been bewitched.

Extract 8:11 Int. 7 m.d (expat).

439. I I see. Hm. Ehm and do you yourself think that anymore eh spiritual reasons
440. for example like witchcraft or God eh that they can have any influence on
441. ehm people's infertility.
442. R ·Hh well I cannot relate to infertility as such, but considering the big part that
443. it obviously plays in other parts of people's lives here I would think so, yeah.
444. I Uhu
445. R It's probably the biggest the biggest eh cause that they think (their)selves
446. anyway.

Extract 8:12 Int 57 m.a

117. I Okay, I see. Yah. (.5) Are there any other main causes you know for
118. for infertility?
119. R Ah there are other ones eh but I am not so sure (what/but) they say eh
120. eh it's <u>traditional</u>.
121. I Hmhm=
122. R = (you know/in our) tradition there are some people they believe that
123. there are some spells, witchcraft [in which] they do that. But eh (.) in
124. I [hmhm]
125. R my sense ehm I am not have a concrete thing. But it might be that
126. some patients they <u>come</u>, they say it might be I've been bewitched
127. that's why I am not have my a children.

In extracts 10 and 11, the respondents are asked about spiritual and traditional causes. In extract 12, the respondent is asked an open question about other causes of infertility. In response, he addresses witchcraft as a cause. [43]

A first observation I want to make is that all three respondents answer in terms of others' rather than their own beliefs about witchcraft as cause of infertility. In extract 10, the respondent states 'Most of *them they* just say ah maybe, my wife has been bewitched.' (lines 358). In extract 11, the respondent refers to 'the big part' that 'it' plays in 'people's lives here' (line 442-443). He adds to this: 'It's probably the biggest the biggest eh cause that *they* think *(their)selves* anyway.' (lines 445). In extract 12, the respondent states: *'they* say (…) there are *some* people *they* believe

[43] This is the only instance in my data in which a biomedical practitioner spontaneously mentions witchcraft as a potential cause. It seems of at least potential relevance that this respondent was a medical assistant; giving non-biomedical explanations may be less problematic for people working in this function than for those higher up in the hierarchy.

that there are to me spells, witchcraft in which they do that.' (lines 122-123). The focus on other people's beliefs is noteworthy, especially in extract 11, as the interviewer explicitly directs her question at the respondent: 'do you yourself think that' (line 439).

Second, respondents make clear that they are uncertain about the non-biomedical causes. The respondent in extract 12 explicitly states 'I am not so sure' (line 119). In addition, by saying 'in my sense ehm I am not have a concrete thing.' (lines 123-125), he suggests that witchcraft is not a firm fact and thus implies that he is uncertain about it as a cause of infertility. In extract 11, the respondent constructs his response as uncertain also by the use of the modal 'would' and verb 'think', in 'I would think' (line 443, Latour & Woolgar, 1996), and 'probably' (line 445). Furthermore, it can be argued that the respondents construct the reality of witchcraft as a cause of infertility as indeterminate by attending to their patients as uncertain themselves. The respondent in extract 10 states that people tell him 'maybe we have been bewitched' (line 361), the respondent in extract 12 that people say 'it might be I've been bewitched' (line 126).

As seen before, the references to others' beliefs and the characterisation of their claims as uncertain make the responses non-committal, that is, the respondents come across as not committed to the reality of supernatural causes like witchcraft.

Third, the respondents make clear that they lack knowledge about the non-biomedical causes: 'I don't know again' (extract 10, lines 356), 'I cannot relate to infertility as such' (extract 11, line 442). These expressions resemble, and appear to function as 'I dunno' formulations, discussed by Potter (1997) and Wooffitt and Widdicombe (2006). These authors argue that 'I dunnos' are a resource for dealing with delicate issues. This is so in part because they formulate what follows as provisional (Wooffitt & Widdicombe, 2006), and enable speakers to display a distance from claims, in particular those which can form the basis for a negative assessment (Potter, 1997). As said in section 8.4.1, acknowledging this reality appears problematic in the light of respondents' orientation to their biomedical expert identity.

Nevertheless, respondents do not explicitly deny the reality of causes like witchcraft or spirits, nor do they dismiss them as non-sensical or irrelevant. In

extracts 10 to 12, two ways can be identified in which respondents avoid dismissing the notion that non-biomedical factors can lead to infertility. First, respondents attend to their cultural relevance. They do this by pointing out other people's beliefs in factors such as witchcraft. In addition, the respondent in extract 12 constructs the belief as 'traditional' (line 120), and therefore as cultural. Furthermore, the respondent in extract 11 attends to the cultural relevance of beliefs by making clear that it plays a 'big part' (line 442) in 'people's lives here' (line 443). By saying that this is 'obviously' (line 443) the case, the respondent attends to the significance of witchcraft as common knowledge, and emphasizes its relevance.

Second, the respondent in extract 10 avoids dismissing the belief in supernatural causes by constructing it as reasonable. He does this by providing an account for why people can have the idea that they are bewitched: 'You are telling me that, she is able to produce, everything is quite alright and I'm alright and we're not producing' (lines 360-361). Here, the respondent attends to the situation that no biomedical problem has been found in a couple without children, which warrants the conclusion that there must be an alternative non-biomedical cause for their fertility problem.

In extracts 13 and 14, a third way in which practitioners avoid dismissing beliefs in non-biomedical causes can be seen.

Extract 8:13 Int. 7 m.d (expat)

476. I and and you yourself do you think that something like witchcraft or
477. infer- eh or God [( )
478. R [we:ll I do believe, I mean I do believe in that there's a
479. big stress or psychological factor in in in eh I mean even, like- I I know it
480. better from a ((home country)) situation, eh where people are just trying trying trying
481. trying to get children, they never get children and they try everything and they
482. [try whatever,
483. I [yah
484. R and they don't get pregnant, they give up,
485. I Uhu
486. R they give up trying to get children, and boom they get pregnant.
487. I Yah
488. R You see that a lot.

Extract 8:14 Int. 9 gyn. (expat).

572. I And do you think yourself that there are any more either spiritual or
573. traditional factors why people can become infertile sometimes.
574. R Yah, I I think there are eh I think there's a strong psychological component in
575. infertility.
576. I Uhu yah.
577. R Ehm I think fertility is not just black or white you know I don't think you just,

578. either fertile or not fertile. Because a lot of women in the (western home
579. country) who tried for a number of years to get pregnant eh adopt, they decide
580. to adopt. And then they get pregnant!

The respondents are asked about their opinion about 'witchcraft', 'God' (extract 13, line 476-477) or 'spiritual or traditional factors' (extract 14, lines 572-573) as causes of infertility. Both respondents provide an affirmative response: 'I do believe' (extract 13, line 478) and 'Yah' (extract 14, line 574). However, they subsequently both re-frame spiritual or traditional causes as stress and psychological factors. In extract 13, the respondent states that 'I do believe in that there's a big stress or psychological factor' (lines 478-479). In extract 14, the respondent states: 'I think there's a strong psychological component in infertility.' (line 574-575). This strategy of acknowledging spiritual or traditional causes in terms of stress or psychological factors can be seen as another way in which respondents avoid discarding beliefs in witchcraft and other non-biomedical causes.

In this way, the respondents avoid dismissing beliefs in non-biomedical causes, in a manner which is reconcilable with their identity of biomedical expert. They manage their identity of biomedical expert also by making their claims regarding stress and psychological factors as causes of infertility reasonable and warranted. The respondents do this first of all by describing observations which sustain their claims, namely of people who try hard to get children, give up and then suddenly fall pregnant (extract 13, lines 480-486, extract 14, lines 578 to 580). Second, respondents warrant their claims by making clear that their observations which sustain them are recurrent: 'you see that a lot' (extract 13, line 486) and 'a lot of women' (extract 14, line 578). Third, in their descriptions, the respondents stress the sudden unexpected nature of the pregnancies they observed. In extract 14, the respondent does this by her exclaiming intonation when she states 'and then they get pregnant!' (line 580). In extract 13, the respondent attends to the enduring effort put in by people to get children, made relevant by repetition of 'trying' (lines 480 and 486), use of the extreme case formulations in 'they *never* get children' (line 481) and 'they try *everything*' (line 481), and by pointing out 'they try whatever' (line 482). This makes the pregnancy all the more unexpected, as does the respondent's description of the pregnancy as 'boom they get pregnant' (line 486). Here, the

respondent refers to the pregnancy as an 'explosive' event. By highlighting the unexpected nature of the pregnancies, the respondents make it conceivable that an alternative, non-physical factor contributed to the fertility problem. Fourth, the respondents make clear that their observations are based in their own western home country (extract 13, line 480, extract 14, line 578-579). As a result, the respondents imply that they have a certain authority to know about these matters, as the respondent in extract 14 makes explicit: 'I know it better from a (name home country) situation (line 480).

The observation that respondents avoid dismissing beliefs in supernatural causes, suggests that rejecting these beliefs is problematic. The next extract suggests why this could be the case.

Extract 8: 15 Int. 7 m.d, expat ((the respondent has been talking before about witchcraft as cause of infertility, and stated that 'it's almost impossible for me to (.) even get involved in that'))

489. I Get involved in in in what, in-?
490. R WELL, it's already difficult to find out because, eh well many people do think
491. that that we all think it's rubbish anyway,
492. I uhu
493. R he, we white doctors here, practicing (.) western medicine.
494. I Yah
495. R So they they don't even tell, or if they tell they start [laughing themselves.
496. I [hm:
497. R Whereas [(.) I do take it seriously, and find it interesting especially,
498. I [okay

Before extract 15, the respondent has talked about witchcraft as cause of infertility, and has pointed out that it is 'impossible' for him 'to get involved in that'. In his explanation for why this is the case, the respondent attends to, and forestalls the possibility of being seen as an ethnocentric doctor. The respondent evokes the identity category 'we white doctors practicing western medicine' (lines 493), and argues that 'many people do think that that we all think it's rubbish anyway' (line 490-491), because of which people 'don't even tell' or 'start laughing themselves' (line 495). He thus attends to a shared notion that white doctors, like himself, think witchcraft is 'rubbish', which implies that white doctors are seen as ethnocentric. The respondent rejects this assumption as not applying to himself by pointing out 'I do take it seriously, and find it interesting especially' (line 502). Thereby, it can be argued, the respondent portrays himself as culturally 'open' and avoids being seen as an ethnocentric white doctor. It can therefore, tentatively, be argued that not

dismissing the idea that non-biomedical factors affect people's fertility is a strategy for western, expatriate doctors to forestall being typified as an ethnocentric doctor, without placing their biomedical expertise at risk.

However, Malawian biomedical practitioners also avoid dismissing non-biomedical causes. I have shown how respondents attend to beliefs about supernatural causes as culturally relevant. It seems reasonable to expect that this makes dismissing such beliefs problematic for respondents who are recognizably members of the same cultural community. The last extract I want to discuss in this chapter, supports this idea.

Extract 8:16 Int. 43 nurse (Malawian)

894. I H- how do you yourself think about that, can people be bewitched and
895. therefore not able to produce.
896. R For myself?
897. I uHu
898. R Hhhuhu ah <u>yes</u>, they can.
899. I uhu
900. R You know, I have been brought up in the village, so (.) I hear those (type), I
901. believe also that there also people being bewitched.
902. I Yah.

The respondent is asked whether she thinks that witchcraft can make people unable to produce. The question appears to raise difficulties, considering the respondent's laughter (line 898, Jefferson, 1984; Haakana, 2002) and considering that the respondent treats her confirmation that people can be become infertile due to witchcraft ('<u>yes</u>, they can', line 898), as accountable. In her account, the respondent attends to her witchcraft belief as something which she shares with others, and thus as something which is common: 'I believe also' (line 901). In addition, in her explanation for her belief, the respondent makes relevant her village background and identity: 'I have been brought up in the village' (line 900). This suggests that respondents take into account an identity of 'villager', or in a wider sense, 'cultural member', and its accompanying expected and proper attributes when discussing witchcraft or other non-biomedical causes of infertility. In other words, it appears that at least in some instances, Malawian biomedical practitioners juggle their identities of biomedical expert and cultural member when proffering their views on non-biomedical causes.

8.5 Summary and Discussion

In this chapter, I have shown how both biomedical practitioners and indigenous healers make their claims regarding causes of infertility persuasive, often in response to mild challenges to their claims. Biomedical practitioners also attend to the basis of their knowledge claims. In so doing, they make relevant various CBAs and, thereby, work up their identity of medical expert. Hence, the relevance of this identity, and expectations that medical experts ought to know about causes, appears to inform the rhetorically strong design of the responses. Respondents' 'hedging' can be seen as another, more defensive strategy by means of which respondents defend their medical expert identity. By signalling minimal commitment to their claims regarding causes, respondents can forestall that challenges of their claims lead to negative typifications of improper, misinformed medical 'expert'. I have shown that also indigenous healers make their claims about causes persuasive. As it is to be expected that also indigenous healers are seen as people who know, and ought to know, about causes of infertility, I have argued that also healers' persuasive design appears informed by an identity project of 'illness expert'.

Furthermore, I have shown that biomedical practitioners' claims about non-biomedical causes are ambiguous and non-committal. They attend to accepting the reality of supernatural causes as being in conflict with being a biomedical expert. At the same time, it appears that rejecting non-biomedical causes can problematic as well. For expatriate practitioners, this is so because of the risk of being seen as ethnocentric, for Malawian practitioners, because of their membership of the culture, to which these beliefs are constructed as germane.

I have shown then, how both biomedical practitioners and indigenous healers' claims about causes are informed by the interpersonal and interactional issues of accountability for claims about causes, in relation to the identity categories made relevant by the respondents and accompanying normative expectations. The analysis presented contributes to an understanding of the social nature of indigenous and biomedical practitioners' views, as it diverges from treating physicians' views as representations of universal, decontextualised textbook knowledge, or cultural

cosmologies. The analysis also provides new insights into the social nature of practitioners' views and practices regarding infertility. With the exception of Inhorn (1994), so far, studies have examined practitioners' views and practices for their normative and moral consequences for the patients. In this chapter however, I have drawn attention to the interpersonal issues at stake for practitioners themselves.

The analysis corroborates findings from other conversation analytic (CA) studies which have used data from doctor patient interactions. I have already described Peräkylä's (1998) work, which shows how doctors attend to their accountability, amongst others ways by making relevant empirical evidence, especially when their expertise is challenged. In addition, several of these CA studies have shown how expertise is co-constructed and established in doctor-patient interactions (Gill, 1998; Maynard, 1991, Pomerantz & Rintel, 2004). Like these studies, my analysis shows how medical expertise and expert identities are worked up and negotiated in interaction.

There are also studies, which have not used CA, which have pointed at the relevance of medical practitioners' professional identity for their practices. For instance, as mentioned in the introduction, Inhorn (1994) argues that physicians' limited disclosure of information to patients is related to the maintenance of professional boundaries. Pinder (1992) points out how for doctors, diagnosing is a prestige-enhancing accomplishment, or in other words, a way to demonstrate and bolster their professional expertise.

These findings form other studies suggests that my analytic findings may be of relevance for interactions and practices taking place in consultations between practitioners in Malawi and people with a fertility problem. I will return to this issue which in the discussion of this thesis, when I address potential practical implications of the findings of this thesis.

In my analysis, I treat biomedical and traditional practitioners' claims as on a par, in that they are both social in nature and informed by interpersonal and interactional concerns. At the same time, I have also pointed at differences in biomedical practitioners' and indigenous healers' constructions of causes. For instance, addressing non-biomedical causes appears to evoke additional inferential difficulties for biomedical practitioners. In addition, my data does not contain

instances of indigenous healers hedging their claims. Both the literature on indigenous healers and my interview data suggest that healers are monitored by, and receive training from hospitals, and are expected to refer their patients to the hospital. However, biomedical practitioners are not monitored by healers, do normally not receive training from them, nor do they refer their patients to them. This suggests that healers face more scrutiny and scepticism regarding their competence than biomedical practitioners. This may prevent healers' from attending to their knowledge claims as uncertain, like biomedical practitioners do. I will return to this issue in the next chapter.

Considering that respondents make relevant their expert identities, I will examine in the next chapter data in which it seems particularly likely that issues of medical expertise and competence are at stake, namely interview extracts in which practitioners discuss successes and problems in helping fertility patients.

Chapter 9. Establishing professional competence

The importance of effective, high quality health-care is widely acknowledged. This can be inferred for instance from efforts put in the development of adequate assessments of clinical competence and performance (Hays et al., 2002; Norcini, 2003; Parboosingh, 1998), and the central role of audits and evaluations in biomedical practice (Teasdale, 1996). Langer et al. (1998) point out that the quality of care is also increasingly being scrutinized in developing countries, in which there is a growing call for auditing of care (Maher, 1996; Wagaarachchi, Graham, Penney, McCaw-Binns, Antwi & Hall, 2001).

Considering the emphasis on the need for high quality, effective care, it is not surprising that problems in health care, such as medical errors, non-adherence of patients to treatment, patients' dissatisfaction or problems in doctor-patient communication have been widely studied. So far, studies have predominantly focussed on the identification of factors which can explain and predict the quality of, and problems occurring in, health care (Lutfey, 2005), based on (statistical) analyses of clinical records, or data regarding providers' and users' views collected in interviews or surveys. In addition, in order to assess the quality and style of communication between doctors and patients, their interactions have been analysed as well, most commonly by means of forms of content analysis, in particular 'Interaction Analysis Systems' (Marks et al., 2000).

Explanatory factors put forward for the different problems in health care overlap significantly. They can be clustered together into characteristics of doctors (e.g. attention or motivation) and patients (e.g. personality, health beliefs); treatment factors (e.g. side effects); organisational factors (e.g. waiting time, equipment failure) and interactional factors (e.g. patient- or doctor centred communication style) (Crossley, 2000; Marks et al., 2000; Department of Health, 2004; Vincent, Taylor-Adams & Stanhope, 1998; Smith, 2004).

The search for objective factors which predict medical failures and problems has, largely, precluded attention to providers' views (D'Ambruoso, Abbey & Hussein, 2005; Hernan, 1993; Lutfey, 2005). The literature discussed above pertains

to biomedical practices. The quality of traditional healing has received much attention as well, in particular in terms of its effectiveness, including any potential harmful effects (Courtright, 1995; Homsey, 1999; Peltzer, Mngqundaniso, Petros, 2006; Waldram, 2000). However, as Waldram (2000) points out, assessments of the efficacy of traditional medicine are normally carried out from a scientific, biomedical perspective. Occasionally, patients' views of efficacy are taken into account, but attention to the views of indigenous healers on their successes *and* failures is lacking (op cit.). Nevertheless, it has been argued that (biomedical) practitioners' views will matter for the care they provide (see also chapter 2, section 2.4; Belizan, Villar & Belizan, 1979; Lutfey & Ketcham, 2005), the prevention of problems such as non-adherence (Lutfey, 2005), and accomplishing changes in the provision of care (Langer et al., 2002). Hence, it has been argued that ultimately, biomedical practitioners' views will affect the quality of care (D'Ambruoso et al., 2005; cf. Langer et al., 2002; Langer et al. 1998), and presumably this would hold true for indigenous healers' views as well. It therefore seems useful to examine both biomedical *and* indigenous practitioners' views of the care they provide, and the way they thereby construct problems and successes encountered.

There is a second reason why this is of interest. I have shown in the previous chapter how traditional and biomedical practitioners attend to, and work up, their expert identity when talking about causes of infertility. Questions about successes, and in particular failures and problems, appear to bring issues of expertise and competence into sharp relief. Whilst successes are in keeping with expected category bound attributes of competent practitioners, failures and problems at odds with them, and may have highly problematic consequences such as loss of clientele or disciplinary actions. The pertinence of such issues is indicated by the reluctance of practitioners', at least those working in the west, to report medical errors (DoH, 2004; IOM, 2000; Marks et al., 2005), which has been attributed to practitioners' fear of disciplinary actions, litigation and loss of self-esteem (DoH, 2004). Hence, it seems worthwhile to examine how professionals manage their competence, when talking about quality issues in the care they provide.

The analysis presented in this chapter is based on an analysis of practitioners' responses to questions about successes, failures and problems in helping infertility

patients. As the literature reports that biomedical means of treating infertility are highly limited in sub Saharan Africa, I was struck in the initial phases of analysis by indigenous healers' recurrent avowals of success in helping infertility clients, and their denials that they faced problems in helping these patients. This suggested to me that practitioners' claims could be usefully treated as serving an interpersonal function, namely of bolstering their (perceived) competence. Therefore, I decided to examine in more detail how both indigenousl healer and biomedical practitioners can establish themselves as successful, competent practitioners in talk about successes, as well as failures or problems. This chapter will contribute to the argument that traditional and biomedical practitioners' views regarding success, failures and problems are of a fundamentally social nature, in that they serve particular interpersonal functions. This insight is important because, as is suggested by the literature, it is likely that practitioners' accounts and constructions will have practical implications for the quality of care.

9.1 Constructing oneself as successful and competent

In the first three extracts which I want to discuss, the respondents make relevant their success in helping infertility patients.

Extract 9: 1 Int. 38 ind.h

108.I	Cause do you also		
109.	have medicines to help		
110.	the man if he has a		
111.	problem?		
112.T		*She is saying do you have*	Wakuti kasi muli nayoso
113.		*medicine if a man is, has this*	mankhwala ya mwanalume kuti
114.		*problem?*	usange wawe wanaproblem iyo
115.R		*Hm::*	
116.T	Yes, she has the such		
117.	(medicines).		
118. R		*I use pounded herbs, they are*	Nkhuyesa wakupula makuni ya-
119.		*usually 3, after pounding this*	kuwapo yalinga yatatu sopara
120.		*tree, then I sieve very well*	napula makuni yala mbwenu
121.		*and tell him to put in tea, to put*	nkhusefa makola nkhuti waka-
122.		*in tea, as he goes to sleep he is*	thire mu tea para wakuthira mu
123.		*supposed to eat a little roasted*	tea para wagonenge wakwenera
124.		*maize. One week, that's it, he*	kurya tuvingoma twakukazinga
125.		*will be on the road. Yes!*	tuchoko. One week basi walipa-
126.			msewu. Eeh!
127.T	Okay. She says,		
128.	she takes two or three		

129. herbs the she pounds
130. those into flower like
131. then she advises that
132. man to take a little
133. flower and put it into
134. tea so that whenever
135. she tastes that tea it
136. goes straight and
137. possibly within a
138. week or two then he's
139. assisted.
140.I Okay. Oh, that's quite
141. quickly. Yah.
142.T Hhuhu
143.I Okay.
((respondent gets up and walks to a pile of dried roots in the room))

146.R	*Here are the herbs*[44]	*Munkhwala wake ni uwu.*

Extract 9:2 Int. 5 ind.h ((Just before the extract, the respondent has discussed how she refers people sometimes to the hospital when she fails to help them.))

888. I Yeah. Okay. Good,
889. thank you very much
890. those were my
891. questions for now.

442.T	*She has finished what she came*	Wakuti iye vyake vyamala ivo
443.	*here for*	wangwizila
444.R	*So let's tell her more. If*	So timphalire vinyake, para
445.	*someone does not have a*	nthowa walije tikutola
446.	*passage for the baby, we*	mankhwala tikuwika mukati
447.	*can put some medicine in a*	mukaplastic tikuputa kuti
448.	*plastic and blow to make the*	nthowa yinyoloke.
449.	*passage straight*	
450.T	*What kind of plastic?*	Plastic yamtundu wuli?
451.R	*Small tubes like the small*	Tumachubu ngati tumahosipaipi
452.	*hosepipe*	tuchoko.

453.T She says at times when
454. the: when there' s
455. (imperforation) of the
456. vagina she gets the
457. drug and puts it in a
458. tube which is (passing)
459. than then she (.) I mean
460. blows of (sort of)
461. blowing the drug
462. through the (.) the
463. vagina so that it can be
464. (.) perforated.
465.I O::kay. I see=
466.T =( )=
467.I =Uhu. Okay. Good.
468.T [Yeah.

469.R	*[If we do this twice then we stop*	[Para tapanga kawiri basi
470.	*and tell her to continue taking*	tuimika tasi kuti amwe waka
471.	*the oral medicine when she*	para amala wula akusanga aima
472.	*completes this course she*	ananthumbo.

[44] 'Herbs' can also be translated as 'medicine'

473. *discovers that she is pregnant.*
474.T She mostly (does it
475. right). Thereafter she
476. will send them (observe)
477. so she finds that most
478. of the times (that lady
479. becomes pregnant)
480. I Okay. I see.

Extract 9:3 Int. 43 nurse

((respondent has just been asked whether patients follow her advice, and answered that she does not know as patients 'don't come back' and 'there's no way we follow them'))

760. I No, you don't get any feedback about where [they're going or what's
761. R [no: no no
762. I happening.
763. R No.
764. I yah
765. R there are a few, the one I remember that one is a primary school teacher.
766. I Uhu yah
767. R After I had counselled, I have done everything, she was just okay. Then I
768. (palpated), then I said can you follow your fertility awareness days. I
769. explained I gave the calendar method. After, she phoned, she became
770. pregnant.
771. I Okay
772. R The last thing I saw she brought a child. Now calling her that child, she was a
773. girl, my name.
774. I O::h.
775. R She always (came to ask me) my name. I forgot about your name, this child I
776. should give your name. It's the one who (here I knew) she gave me the
777. feedback.

The responses in the extracts above have several features in common. First, all three of the respondents make relevant successful outcomes: they point out that their patients' fertility problems are solved. In extract 1, the respondent describes how when she treats men, 'in one week, that's it, he will be on the road' (lines 125-126). Hence, she makes clear that a man's fertility problems will be solved, and moreover, that they will be solved quickly. In extracts 2 and 3, both respondents refer to patients who became pregnant (extract 2, lines 472- 473; extract 3, line 769-770).

A second feature which the responses share is that the respondents construct the successful outcome as contingent on their actions (cf. Pomerantz, 1978). They do this by first describing their actions (extract 1, lines 118-125; extract 2, lines 444-449 and 469-472; extract 3, lines 767-768), and then using the temporal adverbs 'whenever', 'when' and 'after' to connect the successful outcome to their actions. In extract 1, the interpreter mentions that '*whenever* she tastes that tea (…) with a week or two then she's assisted' (line 134-139). 'Whenever' implies that the 'assistance'

follows the moment of tasting of the tea. Likewise, in extract 2, the respondent states that '*when* she completes this course she discovers that she is pregnant' (lines 471-473), thereby making clear that the pregnancy follows in time the (completion of) the course of medication. In extract 3, the respondent states that 'after' (lines 767, 769) her interventions and advice, the patient phoned to say that she is pregnant (line 769). The respondent thus makes clear that the (announced) pregnancy occurred after her interventions.

By making relevant their success, and constructing this as contingent on their actions, the respondents can be seen to portray themselves as competent practitioners.

9.2 Making claims of success and competence persuasive

The respondents in extracts 1 to 3, can be seen to use several devices, by means of which they make their claims of success factual and persuasive. First, in extracts 1 and 2, the respondents provide various details regarding their treatment, for instance about the number of herbs used ('three', extract 1, line 113), how medicines are administered ('pounded', 'put in tea', extract 1, lines 118-121; taken together with 'a little roasted maize', extract 1, line 124-125; blown through 'a plastic', extract 2, line 448), when they should be taken ('as he goes to sleep', extract 1, line 122) and how often ('twice' extract 2 line 469). By providing these details, respondents demonstrate their knowledge regarding treatment for infertility. The respondent in extract 1 reinforces this by showing the medicine to the interpreter and interviewer (line 146), and thus giving empirical evidence of her knowledge and possession of medicine which can cure men's infertility.

Second, in extract 3, the respondent demonstrates her knowledge of treating infertility by using relatively formal and specialist terms, such as 'fertility awareness days' (line 768) and 'the calendar method' (line 768). Thereby she makes relevant her knowledge of standardized, accepted methods of treating infertility, and thus sustains, and makes more persuasive, her claim of success and competence.

Third, in extract 3, the respondent points out that 'the last thing I saw, she brought a child' (line 771). By referring to her own direct observations, she provides empirical proof for her claim of success.

Fourth, the respondent makes her construction of her interventions being successful convincing by pointing out that her client wanted to name her baby after her: 'now calling her that child, she was a girl, my name.' (lines 771) and 'she always (came to ask me) my name (…) this child I should give your name' (lines 773-774). Here, the respondent uses a form of corroboration (Potter, 1996), in that she puts forward a 'witness' who acknowledges and supports her claims regarding successful interventions, thereby making it more persuasive.

Fifth, in extract 1, the interpreter makes the respondent's claim persuasive as well. He translates the respondent's claim that 'one week, that's it, he'll be on the road' as 'possibly within a week or two, then he will be assisted' (lines 139-141). 'Within a week or two' tones down the swiftness of the cure achieved, 'possibly' characterises the cure, or the time scale, as uncertain. Hence, the interpreter plays down the efficacy of the respondent's medication. In so doing, he can be seen to bolster it against sceptical reactions, which the claim that patients are 'on the road' within 'one week' could invoke. Consequently, the interpreter makes the claim of success more persuasive. Nevertheless, the interpreter still makes clear that the respondent's patients will be helped quickly, as can be inferred as well from the interviewer's reaction in lines 140-141, when she states: 'Oh that's quite quickly'.

Especially in extract 2, the respondent's portrayal of success and the design of this claim as persuasive appears to be touched off by the interactional context. Just before the extract, the respondent mentioned how she sometimes fails to help infertility patients. Thereby she arguably opened herself up to doubts regarding her competence, in particular because immediately thereafter the interviewer and interpreter indicate that the interviewer has obtained enough information ('she has finished what she came here for'), and initiate closure of the conversation (lines 438-443). The respondent can be seen to inoculate herself from doubts regarding her competence by re-opening the conversation with 'so let's tell her more' (line 444) and making relevant her success, in a persuasive manner.

In extract 4 too, the respondent bolsters his claim of success when it appears to be doubted.

Extract 9:4 Int. 21 ind.h

825.I And, but so do
826. you usually manage to
827. (.) help people who
828. come to you who (.)
829. want to have children,
830. do they usually
831. succeed in having
832. children after they
833. have been [to you.
834.T *[She says, from the people do they get uh*
835. *children? The people you help?*
836.R *That is why you see a lot of friendship. They*
837. *come with the children. If you help eleven*
838. *people to bear children, is that not a lot?*
839. T He's saying that he has
840. helped eleven out of- from the eleven
841. people of- have you-=
842.T *=Have you helped eleven people only?*
843.R *Here in Mangochi I can say that I have helped*
844. *eleven but in Makanjira Ihh=..*
845. *=How many have not been successful? In*
846. *your whole life how many people have been*
847.T *unsuccessful in bearing children?*
848. *A lot.*
849. *Are there some who have failed? The ones*
850. *who have been unable to bear children?*
851. *The ones who have failed to have children.*
852.R *Ye::s.*
853.T *They are there?*
854. *They are there, but there are three of them*
855.T *Okay*
856.R *Yah*
857.T So he's saying that he has helped
858. eleven people to have
859. [children.
860.I [hmhm
861.T Those have successfully now bear
862. (.)
863.I Hmhm=
864.T =children.
865.I Yah.
866.T But only possibly three of them e:h
867. failed to have. [Children.
868.I [Okay.
869.T Yes.
870.I That's a very h[igh success r-hhu-ate.
871.T [possibly
872.T hhhahaha.
873.I Hm::
874.T yes.

Asked whether the people he helps 'get children' (line 834-839), the respondent makes clear that he is successful in solving fertility problems. He does this explicitly when he refers to successful outcomes ('they come with children', line 837; 'if you help eleven people to bear children', line 838) and implicitly by saying 'that is why

you see a lot of friendship' (line 836). As the respondent has just been asked whether the people he helps get children (line 828), he can be seen to imply that the friendship, is due to his successful assistance.

The respondent uses several discursive devices to make his claim of success persuasive. First, his use of numerical detail 'eleven people' (line 838) strengthens the factuality of his claim of his success (Edwards & Potter, 1992; Potter, 1996a; Wooffitt, 1992). Second, the respondent uses a rhetorical question to make clear that his success is considerable: 'if you help eleven people, is that not a lot?' (line 838-839). The question is rhetorical, in part because it is treated as not in need of an answer by the interpreter, who immediately translates it as a statement 'he has helped eleven' (line 841). Therefore, the question has as function to make a point, namely that having helped eleven people is 'a lot', rather than to ask a question. Hence, the respondent establishes his success rate as high. Third, when this construction is challenged by the interpreter, who says 'have you helped eleven people *only*?' (line 843), the respondent upgrades his success rate. He does this by providing additional information: 'Here in Mangochi I can say that I have helped eleven, but in Makanjira I' (line 844-845). Thereby the respondent reframes the eleven people he helped as only part of his success, and implies that his total success rate is larger than 'only' eleven.

Fourth, the respondent sustains his construction of success rate as high by pointing out, when asked (line 849-851), that the number of failures is significantly smaller. Asked 'how many have been unsuccessful' in his life (line 849), the respondent states initially 'a lot' (line 849). However, in response to the interpreters' probe, 'are there some who have failed?' (line 850), the respondent heavily tones down 'a lot' into the 'there are three of them' (line 855). As in line 838, the numerical detail makes the respondent's claim persuasive, also because it contrasts with the more vague description 'a lot'. In addition, three is a small, but reasonable number, and therefore makes the respondent's claim more realistic than '1' or 'none' would have done. The interpreter attends to three as 'few' by contrasting it, by means of the contrast marker 'but', with the eleven success cases: 'he has helped eleven people to have children' (line 867-868), 'but only possibly three of them eh failed to

have children' (line 870-871). In addition, he portrays three as a small number by saying 'only' (line 867).

Hence, the respondent constructs himself as successful, and makes this convincing, in part when challenged. The interviewer's upshot in line 871-872 sustains this analysis of the respondent's establishment of himself as being highly successful. As Watson and Heritage (1984) have pointed out, upshots select and propose the meaning of the preceding utterances, in this case that the respondent's success rate is high: 'that's a very high success r-hhu-ate' (line 874).

However, some further observations show that constructions of success are not necessarily taken at face value. In line 872, whilst the interviewer produces an assessment of the respondent's success rate as high, the interpreter comes in, saying 'possibly'. Thereby he calls into question the respondent's high success rate. The interviewer appears to pick up on this by her (sniggering) laughter towards the end of her assessment: 'success r-hhu-ate', which is followed by the interpreter's laughter (line 873). The laughter makes the assessment hearable as ironic, and implies that the respondent's claim of success is not straightforwardly accepted.

In conclusion, at least some respondents construct themselves as successful in solving fertility problems, and thus as competent practitioners. In some instances, they do this when it can be inferred that their competence may be doubted. This suggests that the respondents have a stake in coming across as skilful practitioners. It is noteworthy that only extract 3 is from an interview with a biomedical practitioner; the others are from interviews with indigenous healers. In addition, extract 3 is the only extract in which the respondent attends to her success in a specific case, whereas in all other extracts, the respondents make relevant their success in general. This appears to reflect a more general pattern in the data. There are seven[45] indigenous healers who point at their success in treating infertility patients, and six biomedical practitioners. All of the seven indigenous healers, who point at their success in solving their patients' fertility problems, make clear that they are in general[46] able to cure infertility, whereas of the six biomedical practitioners who acclaim their success, four make clear that they have been successful in specific

[45] For a discussion of issues involved in counting, see chapter 10.
[46] 'In general' does not mean that these respondents indicate that they always solve fertility problems, but that they do so often or usually.

cases. It thus seems that indigenous healers attend to their success more frequently than biomedical practitioners, and construct it as more widespread. I will return to this issue in the next section.

9.3 Dealing with questions about problems in the provision of care

Having shown how respondents construct themselves, persuasively, as successful and competent, I will now examine extracts in which respondents deal with questions about problems in helping patients. Such questions appear particularly interesting as they can be seen to, literally, question the respondents' competence.

9.3.1 Rejecting disappointment

In extracts 5 and 6, the respondents are asked about whether their patients are ever disappointed with the help they get.

Extract 9:5 Int. 30 TBA (respondent has just said that her patients are satisfied with her advice because 'what they look for, they find it')

283.I	Have you also ever		
284.	experienced that		
285.	your patients were		
286.	perhaps disappointed?		
287.T		*She says (.) 'Are there some*	Akuti (.) 'Plai wena amene a-
288.		*that g- (.) et disappoint (.) some*	(.)makhum(.)wena wake
289.		*others that say; 'ah (.) yah, (.)*	amati; 'ah,(.) tja, komabe
290.		*somehow these people, ah*	anthu awa, ah (.)
291.		*(.)they are not really that*	ndizotsathandiza kweni-
292.		*helpful.' Are they there?*	kweni' Alipo?
293.R		*No, I should not lie. There are*	Aiyi, ndisaname. Palibe.
294.		*none.*	
295. I	Okay.[47]		
((interviewer moves on to next topic))			

Extract 9:6 Int. 8 m.a

287.	I	Hmhm okay. Hmhm. And ehm, ·HH so you said that often they are quite
288.		happy with what you tell them because it's new information for them,
289.		ehm have you also seen any time that peop- patients are disappointed
290.		with what you can do for them?
291.	R	Yah, most of the times, to me I have never seen the patients eh being
292.		disappointed.
293.	I	Okay.
294.	R	Just because most of the times I do tell them about the physiology of their
295.		body
296.	I	Yeah.

[47] I speak some Chichewa, and pick up the meaning of the respondent's answer myself.

297. R And they are very much happy to hear since it is the first time to them.

Both respondents are asked whether their patients are ever disappointed in the help given by the respondents. In extract 5, the interviewer's question is translated as whether there are people who say 'somehow these people, eh (.) they are not really that helpful' (lines 290-292). 'These people' appears to refer to the TBA, or similar practitioners. In extract 6, the respondent is asked whether he has 'also seen that patients are disappointed with what you can do for them' (lines 289-290).

Note that this question about patients' disappointment in the respondents' care forms, at least potentially, a problem for the respondents. For, 'proper', competent health practitioners are expected to provide health care which is, at least overall, satisfactory, both according to 'objective' standards and from a patient perspective. In other words, disappointing patients, certainly when this is related to the assistance offered, is at odds with certain category bound activities of practitioners, such as providing satisfactory care.

The respondents appear to deal with the problem posed by the question in several ways. Both respondents deny that they disappoint their patients, first of all by means of direct denials: 'No', 'There are none' (extract 5, line 293-294) and 'I have never seen the patients eh being disappointed' (extract 6, line 291-292). Second, in extract 6, the respondent makes clear that patients are not disappointed by claiming the opposite: they 'are very much happy' (line 297).

The respondents make their claims persuasive. In extract 5, the respondent says 'I should not lie.' (line 293). By framing what she says as not a lie, she stresses its veracity. In extract 6, the respondent accounts for his claim that his patients are happy: 'I do tell them about the physiology of their body' (line 294-295), about which 'they are very much happy to hear since it is the first time to them' (line 297). Hence, the respondent explains the basis for his claim about his patients' happiness and lack of disappointment, thereby making it convincing. In addition, the respondent makes clear that it is his actions (i.e. the providing of certain information) which make patients happy, which aids the construction of his care as being not disappointing. Furthermore, the respondents use extreme case formulations (ECFs), namely 'none' (extract 5) and 'never' (extract 6) in the denials. In extract 5, 'never' upgrades the prior 'most of the times' (line 291). As Pomerantz (1986) has pointed

out, ECFs make the claim persuasive, and are used especially when a sceptical response is anticipated. In both extracts 5 and 6, there are grounds for taking into account the possibility that the interviewer is sceptical regarding the respondents' claims. Both respondents mentioned before that their patients are satisfied, as pointed out in extract 6 by the interviewer: 'you said that often they are quite happy with what you tell them' (line 288). As in a sense, the respondents have already answered the interviewer's question about whether their patients are disappointed, it can be inferred that the interviewer may be sceptical about the veracity of the respondents' claims.

By persuasively denying that their patients are disappointed by their assistance, the respondents forestall the inference that their care is seen as inadequate and thus, it can be argued, that their competence is doubted.

9.3.1 Making oneself not accountable for problems

Nevertheless, respondents do acknowledge at times the occurrence of troubles in helping infertility patients. However, as I will show, respondents account for these problems in a way that they cannot be held responsible for them. Consider extracts 7 and 8.

Extract 9:7 Int. 32 c.o

630. I Okay, yah. Hm. If you would have to give a very rough
631. estimation about how often can you help these patients, how
632. often can you solve their problem?
633. R E- e- we have seen that the prognosis of such people is very low, very low.
634. The chance of having children is very low.
630. I Okay. Yah, so mostly you can't.
631. R You cannot solve the problem. Whatever we, we do have because we
632. cannot we cannot change how their body is making the cells.

Extract 9:8 Int. 50 ind.h

725.I Okay, yah. Ehm,
726. are there any problems
727. you are faced with
728. when you are trying to
729. help this kind of
730. patients?
731.T *She says is there any other* Bati pali suzgo linyakhe ilo
732. *problem that you meet/face* mukusangana nalo para

733.		*when you are helping an*	mukovwira munthu wambura
734.		*unproductive person?*	kubaba?
735.R		*Uhh (.) ah (.) problem (.)*	Uhh (.)ah (.) suzgo (.)
736.T		*Apart from those that you said*	Apart from yara
737.		*those ( )*	mwanguyowoya yara ( )
738.R		*We meet problems. Meeting the*	Suzgo tikusangana nazo.
739.		*(.) problem is like this, me, I*	Kusangana na.(.) suzgo kukuba
740.		*know medicine that help a*	kwakuti nthe, ine, nkhumanya
741.		*person to the point of having a*	mankhwara yakuti munthu
742.		*child. But it happens that (.)*	mupaka wababe mwana. Kwene
743.		*others, with that same tree that*	pakuza sangika kuti (.)
744.		*I used to cure the other patient,*	ŵanyakhe, na khuni lira
745.		*that is it (.) to this other*	nachizgira munyawo lira,
746.		*person, that (.) is also*	mbwenu (.) kwa uyu munyakhe
747.		*unproductive, that is it,(.) it (.)*	uyu, naw (.)wakulekaso
748.		*does not work again!*	kubaba uyu, mbwenu,(.) liku
749.			(.)ligwira ntchito cha!
((several lines omitted))			
755.T		*Is it something to do with the*	Vikukhwafya na mu ndopa,
756.		*blood, or what? The blood*	panyakhe mu vichi?... Ndopa
757.		*according to person, is it?*	umu yiliri ya munthu, eti ?
758.R		*It is like this; as for some of*	Pali nthe; para banyakhe,
759.		*them, they are those that have*	bakuba bakuti, baleka kubaba,
760.		*not been productive for a long*	nyengo yitali.
761.		*time.*	
762.T		*Hm.*	Hm
763.R		*Now, ther: women and we men,*	Sono, paa.(.) ŵanakazi na
764.		*are different.*	tabanalume, tikupambana.
765.T		*Hm*	Hm
766.R		*Women, if they have not been*	Ŵanakazi, para baleka kubaba
767.		*productive for a long time,*	panji nyengo yitali,
768.T		*Hm*	Hm
769.R		*The hous- we say that; "The*	nyu-. tikuyowoya kuti;
770.		*house has fallen."*	"Nyumba yawa."
771.T		*Hm*	Hm
772.R		*Yes. So although you may look*	Eeh. So nawuli ungapenja
773.		*for medicine there, she can't*	munkhwala para, wangachira
774.		*heal! That is it, that one also*	cha! Mbwe yura nayo wakhara
775.T		*just stays like that, like that.*	nthe, nthee.
776.I	Okay.		
777.R		*yes*	Eeh
778.T	Okay, he says at times		
779.	there are some women		
780.	who can – ladies who		
781.	do have a child maybe,		
782.	some past years,		
783.	maybe 10 or 15 years		
784.	ago.		
785.I	Uhu		

786.T He had a child. .
787.I Uhu.
788.T But from there, he
789. have been (hard)
790. finding a boy to have
791. another child with.
792.I uhu
793.T So, as long as the
794. period is very ( ),
795. very (wrong/long) like
796. that, that lady will not
797. have a child again just
798. because his
799. reproductive organ is
800. maybe bad to what, I
801. can say, is over,
802.I [Uhu
803.T [time for her to have a
804. child, is over.
805.I Okay, yah.
806.T So, no matter you can
807. try this [medicine
808.I [Hm
809.T and that, you not do
810. anything,
811.I Okay, yah.
812.T which means that lady
813. will just turn this one
814. a failure, while she is a
815. failure.
816.I Yah, okay, so
817. sometimes it's a
818. problem to help
819. someone if she is
820. basically too old to
821. bear children.

Both respondents attend to the problem of failing to solve people's infertility. In extract 7, asked for a rough estimation of 'how often can you help these patients' (line 631), the respondent points out that 'the prognosis of such people is very low, very low. The chance of having children is very low' (line 633-634). Thereby implies that he cannot often solve fertility problems. In extract 8, the respondent refers to the problem of not being able to cure a patient when he states that 'it happens' that his 'tree', 'does not work again' (line 748), 'she can't heal'(lines 773-774) and 'that one also just stays like that, like that' (line 775).

Both respondents account for why (certain) fertility problems do not get solved, in which they attribute, in several ways, not curing infertility to the kind of people they treat, that is, to their physical constitution. First, in extract 7, the

respondent states ‘we cannot change how their body is making the cells’ (line 636-637). Thereby the respondent implies that infertility, at least infertility which he cannot cure, is due to the way the body makes cells, and thus due to people’s physical constitution. Second, in extract 8, the respondent states ‘women and men, are different’ (line 763), and points out that ‘if *women* have not been productive for a long time (line 766-767), ‘she can’t heal’ (line 773-774). Thus, the respondent suggests that, at least in part, people’s sex, and hence their biological make-up, determines the solvability of fertility problems. Third, by describing the condition of women who have not been productive for a long time as ‘the house has fallen’ (line 769-770), the respondent makes the problem literally, into a problem of the physical foundation or constitution. Furthermore, the interpreter attends to incurable cases of infertility as a matter of people’s physical make-up, when he speaks about ‘his [her] reproductive organ is maybe bad to what, I can say is over’ (line 799-801).

By constructing (certain) fertility problems as due to people’s physical constitution, the respondents imply that failure to solve such fertility problems is not related to their own actions. The respondents make this clear in other ways as well. First, the respondents construct (certain) fertility problems as impossible to solve. In extract 7, the respondent states: ‘you *cannot* solve the problem’ (line 636) and ‘we *cannot* change’ (line 637). Similarly, in extract 8, the respondent says ‘she *can’t* heal’ (line 773-774). Second, in extract 7, the respondent points out that you can’t solve the problem, ‘whatever we, we do have’ (line 636), which can be taken to mean either ‘whatever we do’ , or ‘whatever medicine we have’. In either case, the respondent makes clear that not curing a fertility problem is independent of treatment given. In extract 8, the respondent does this by stating ‘although you may look for medicine there, she can’t heal!’ (line 772-774). In addition, when he mentions that medicine ‘used to cure the other patient’ (line 744) does not work with others, and that he knows ‘medicine that help a person up to the point of having a child’ (line 739-742), the respondent makes clear that he is in principle able to cure infertility. Consequentially, he portrays failure to do so as unrelated to his treatment. The interpreter in extract 8 attends to failure to cure as being independent of the respondent’s medication in his translation: ‘no matter you can try this medicine and that, you not do anything’ (line 806-810).

It is worth noting that the respondents use the pronoun 'we' in several instances: 'we have seen' that the prognosis is very low (extract 7, line 633), 'whatever we, we do', 'we cannot change' (extract 7, line 636), 'we meet problems' (extract 8, line 738), and 'we say that, the house is fallen' (extract 8, line 769-770). 'We' can be seen to fulfil two functions in these extracts. First, it makes respondents' claim more convincing, as it is a form of corroboration (Edwards & Potter, 1992; Potter, 1996), a discursive technique of putting forward 'witnesses' who support one's claims. Hence, by using 'we', the respondents make their claims, that chances of solving fertility problems are low, cells cannot be changed and that 'the house is fallen', into shared factual knowledge rather than subjective opinions. Second, 'we' makes clear that the problem of not curing infertility is faced by practitioners in general, or at least several practitioners, rather than just themselves. Therefore, the use of 'we' aids respondents' construction of failure to cure infertility as independent of their own interventions. In extract 8, the idiom 'the house is fallen' serves the same dual functions. An idiom can be seen as a cultural manner of expression, and is attended to as such by the respondent when he precedes it with 'we say that' (line 769). Thus, by using the idiom, the respondent constructs the idea that certain fertility problems are fundamental and definite as consensual, cultural common sense. As a result, his claim becomes more convincing (cf. Drew & Holt, 1988), and is portrayed as valid for practitioners in general, making the incurability of certain fertility problems independent of the respondent's actions. In extract 7, the respondent's reference to 'prognosis' (line 633) has the same effect. As prognoses are derived from statistical analysis of a number of cases, talking about a bad prognosis conveys the notion that infertility is in general found to be difficult to cure, and not just in the respondent's case. By implication, the respondent suggests that the difficulty in curing infertility is not due to a problem with his own medical interventions.

By constructing failure to solve fertility problems as due to the physical make-up of some infertility patients, and making clear that the incurability is independent of their treatment, the respondents make themselves not accountable for failure to solve patients' infertility. As a result, they prevent that the failures are seen as reflecting problems regarding their competence as practitioner. The interpreter in

extract 8 explicitly attends to, and rejects, the idea that the respondent is seen as a 'failure', and thus as incompetent, due to not solving (some) fertility problems. In line 812-815, he states this 'lady will just turn this one a failure, while she is a failure'. 'This one' can be taken to refer to the healer. Here, the interpreter can be seen to use a reality-appearance device (Edwards, 1991; Eglin, 1987; Wetherell & Potter, 1997), by means of which he makes failure on behalf of the healer into the apparent reality, with failure on behalf of the patient into the 'real', underlying reality. In other words, he diverts accountability away from the healer to the patient and forestalls the perception that the healer is incompetent because of not being able to cure (certain) infertility patients.

Note that in extract 7, the respondent attends to the problem of solving fertility problems of 'such people' in general, whereas in extract 8, the respondent restricts the issue to a specific kind of fertility patient, namely women 'who have not been productive for a long time' (line 759-761). Hence, the respondent in extract 7 constructs failure to solve fertility problems as more widespread than the respondent in extract 8, who moreover, also draws attention to the possibility, and his ability, to solve fertility problems (lines 739-742, 744). The respondent in extract 7 is a biomedical practitioner, and the respondent in extract 8 a traditional healer. Again, these observations appear to reflect a more general pattern in the interview data I collected. Only three healers talk about their failure to solve fertility problems, and all three make clear that their failures pertain to specific (types of) patients. However, eight biomedical practitioners point at their inability to solve fertility problems, and all eight make this pertain to infertility in general. I will return to this issue in the discussion of this chapter.

In the next two extracts, another way in which respondents attribute problems to their patients, and thereby make themselves not accountable for them can be observed.

Extract 9: 9 Int. 62 c.o

417. I I was wondering what, infertility is that from your perspective very difficult to treat or
418. good to treat?
419. R It's easy.
420. I It's easy.
421. R It's easy.
422. I To treat.

423. R Because you depend on first of all examining the woman or the client,
424. whoever it is, examine urine, stool, blood for VDRL, and then you can
425. decide from there. But if at all he really obeys the rules of medicine, there
426. will be no problem. No problem. Because they usually, they get
427. infected. After the infection you want to clear the infection away, but they will mix.
428. You see that's where we get the problem. They will get the medicine okay from the
429. hospital but when they go home they will try the herbalist. So they cannot go well if
430. they mix this and that.
431. I Okay. That's a problem if they mix medicine from the traditional healer and the hospital.
432. R Uhu.

Extract 9:10 Int. 9 gyn (expat.) ((respondent is responding to question 'ehm are there any other kinds of communication problems or misunderstanding you sometimes encounter of which you can give me some examples?'))

482. R Ehm, the other thing is ehm hhu, sometimes like this was more like in
483. ((X))[48] I think that- because you might say to them, I've been doing this for
484. twelve years you know, hhuhu and there's always this misunderstanding in
485. ((X)) where I I'll be talking to the nurses and and or you know I'll have to
486. ask the nurse to translate and I'll say you know we have to tell them that the
487. sperm analysis is abnormal and probably a lot of the problem has to do with
488. the with the husband and they'll say well it's very hard for the husband to
489. accept that. And than I'll go well, pfff ((laughs)) ((smiley voice)) I'm sorry
490. it's very hard for the husband to accept it, but I (.) you know I can only, you
491. know, I only just have my work here as a doctor
492. I yeah
493. R you know I can't really, I don't know how to help somebody accept something
494. I No
495. R That I think is true and that they can't accept. So I'll say I'm so sorry I'm just
496. a doctor and I can't, he ca- they came here because they wanted to have a
497. baby, I'm doing the best I can and if he can't accept it, then he can't accept it
498. , I mean I can't help as I'm at the end of my, what I can do, okay.
((some lines omitted))
529. I Yah yah yah and that's of course yah the end of your limits and if if they can't
530. deal with that then eh you can't help them really

In extract 9, the respondent is asked whether infertility is difficult to treat, in extract 10, the interviewer asks specifically about 'communication problems or misunderstandings' encountered. Note that although the respondent is not asked about her ability to solve patients' fertility problems, it is to be expected that communication problems can lead to problematic inferences as well. This is so because competent practitioners ought to communicate well with their patients.

In their replies, both respondents acknowledge that they experience problems, and they do so in a way that they make themselves not accountable for them. They do this first of all because of the nature of the particular problems they describe. In extract 9, the respondent refers to patients mixing medication: 'they will

[48] X = name of a country in central Africa where the respondent worked before.

mix. You see that's where we get the problem' (line 427-4428) and 'so they cannot go well if they mix this and that' (line 429-430). In extract 10, the respondent mentions a 'misunderstanding' (line 484), namely that when she asks nurses to translate for patients that their sperm is abnormal and that 'probably a lot of the problem has to do' with the husband, they will tell her 'well it's very hard for the husband to accept that' (lines 488-490).

Mixing types of medication, and not accepting a diagnosis, are both problems for which patients can be held more readily accountable than practitioners. In general, patients are expected to adhere to and accept a doctor's advice regarding medication or diagnosis (cf. Parsons, 1951). In addition, according to common sense understandings, practitioners can exert limited influence on whether patients mix medication, or accept their diagnosis.

Second, the respondents imply that their patients rather than they themselves are accountable for problems encountered by constructing their patients as predisposed to respectively mix (extract 9) and not accept a diagnosis (extract 10). They do this by using what Edwards (1995, p. 319) has called 'script formulations', which are descriptions which characterize actions or events as recurring and predictable. The respondents use several of the scripting devices which Edwards (1995) has identified. For instance, the respondents use temporal adverbs like 'usually' (extract 9, line 440) and 'always' (extract 10, line 485), and verb forms with an iterative aspect, in particular 'will', to refer to the problems which they address. Hence, the respondent in extract 9 states 'they will mix' (line 430), 'they will get the medicines okay from the hospital' (line 448-429), and 'they will try the herbs' (line 429). The respondent in extract 10 says 'they [will] say' that its hard for the husband to accept (line 488), and 'and then I'll go well, pf:::' (line 489) and 'I'll say I'm so sorry' (line 495). In addition, the respondent in extract 10 uses an implicit if-then construction: 'when [if] they go home [then] they will try the herbalist' (line 429). Such a construction suggests a law-like regularity in patients' trying of the herbalist (cf. Edwards, 1995).

Furthermore, the respondent in extract 10 portrays patients' behaviour as scripted by constructing men's problems with accepting the diagnosis that 'a lot of the problem has to do' with them as a cultural issue. She does this by locating the

issue in a specific African country: 'this was more like in (X)' (lines 482-483) and 'there's always this misunderstanding in (X)' (line 485). In addition, in lines 484 to 485, the respondent says 'I've been doing this for twelve years you know'. Before, she explained that she worked for 12 years in this other African country. Hence, the respondent can be seen to make relevant that she possesses specific 'insider knowledge' due to an enduring stay in the setting. As a result, she makes the phenomenon she describes into a cultural issue, for the understanding and explanation of which local knowledge is useful, if not necessary. By constructing men's inability to accept a diagnosis as cultural, the respondent portrays it as common, shared and thus recurrent and predictable (see also chapter 4).

As authors like Edwards (1995) and Smith (1978) have pointed out, descriptions of practices as recurrent and predictable make available inferences about the disposition of the actors. Likewise, I argue that, by using script formulations the respondents construct their patients' mixing of medicine and lack of acceptance as being due to some (cultural) disposition on behalf of their patients. Consequently, the respondents themselves cannot be held accountable for these problems, and they do not reflect badly upon their competence.

The respondents can be seen to attend to their own lack of accountability for the problems experienced. First, the respondent in extract 9 makes clear that that there is no problem with the treatment which he gives to patients. He does this when he states 'They will get the medicine okay from the hospital' (line 428-429). As the respondent is a health practitioner who works in a hospital, he can be seen to imply that his own medication as 'okay'. The respondent reinforces the problem free status of his treatment by constructing treating infertility as 'easy' (lines 419, 421), and by pointing out that if a patient 'obeys the rules of medicine, there is no problem' (line 425-426). Hence, the respondent constructs problems in solving fertility problems as dependent on the behaviour of the patient rather than on his own medical interventions, or 'the rules of medicine', and makes himself not accountable for them.

Second, the respondents attend to their lack of accountability by suggesting that the problems they encounter, and solving it, falls outwith their realm, or responsibility, as a doctor. In extract 10, the respondent makes this explicit, when she

states ‘I only just have my work here as a doctor’ (line 492), ‘I’m just a doctor, I can’t-’ (line 496-497). She thus makes relevant her identity as doctor, and makes clear that this has implications for the kind of work she can do. More specifically, the respondent makes clear that dealing with the problem of patients being unable to accept a diagnosis is not a category bound activity of the identity category ‘doctor’. She does this when stating: ‘I don’t know how to help someone accept something’ (line 493) and ‘if he can’t accept it, then he can’t accept it, I mean I can’t help as I’m at the end of my, what I can do, okay’ (line 497-498). Note that considering that the respondent has just made relevant her identity as a doctor, she occasions the inference that the limitations are ‘category bound’, rather than personal. The interviewer shows to infer that the respondent implies that solving problems of acceptance falls outside the respondent’s realm as a doctor when she says: ‘that’s of course yah the end of your limits and if if they can’t deal with that then eh you can’t help them really’ (line 530). By constructing the encountered problem and solving it as falling outwith her work remit as a doctor, the respondent becomes not accountable for it. The respondent in extract 9 achieves a similar effect by pointing out that problems occur ‘when they go home’ (line 429). Arguably, according to common sense understandings, doctors cannot be reasonably expected to control what happens at their patients’ homes, in their absence. Hence, the respondent attends to his lack of accountability for patients’ mixing of medication.

Third, in extract 10, the respondent and interviewer do this by constructing the respondent as unable to do something about patients’ inability to accept a diagnosis: ‘I *can’t* help’ (line 498) and ‘you *can’t* help them’ (line 530).

Fourth, in extract 10, the respondent states ‘they came here because they wanted to have a baby, I’m doing the best I can’ (line 497-498). Here, the respondent makes clear that she has responded to their patients’ request, and moreover that she has responded as well as she can. Hence, the respondent suggests that she has done her ‘duty’, and makes clear that she is not held to blame.

Thus, as in extracts 7 and 8, the respondent in extracts 9 and 10 make their patients, rather than themselves accountable for problems encountered, this time by attributing them to their patients’ behaviour and underlying dispositions. This is especially noteworthy in extract 10, as the respondent is asked about communication

problems, which could easily be seen as caused by factors residing in patients *and* health practitioners, in particular because the practitioner is born and trained in the west. This makes it seem reasonable to expect that the practitioner may lack certain language skills or cultural knowledge which could lead to communication problems. However, the respondent in extract 10 is not the only western practitioner who constructs herself as not accountable for communication problems experienced. Consider extract 11; like in etxract 10, the respondent is also an expatriate gynaecologist.

Extract 9:11 Int.18 gyn.(expat.)

1100. I Okay, yah I see ehm do you also sometime experience maybe certain eh
1101. misunderstandings between you and patients
1102. R Oh you- there's a lot of misunderstandings I mean eh ehhh (1) because they
1103. they eh yah they have no idea what problems they have. He of course often
1104. they do- they have heard of the womb, they have heard of the tubes but that's
1105. all what they he what thet know he and if you tell people just what I said the
1106. woman who has cancer and you tell them that she's going to die from from eh
1107. cancer if nothing is done, well eh probably she doesn't realize
1108. I uhu
1109. R that he what it means although she she speaks English he that means she <u>is</u> a
1110. bit educated
1111. I uhu but she doesn't rea- realize what that means
1112. R No she doesn't real- yah lots of women they have no idea about wombs
1113. etcetera
1114. I Okay yah hmhm.
1115. R he although probably they slaughtered some animals ,
1116. I Hhuhu
1117. R but the wombs of animals are different from wombs of eh people
1118. I Uhu okay yah
1119. R he and eh so I'm I'm definitely sure that there's a lot of misunderstanding
1120. I Okay yah
1121. R but also because I don't speak the language,
1122. I Yah.
1123. R He, so so I have always an interpreter
1124. I Uhu
1125. R and I'm not hundred percent sure if she tells what I'm telling the woman.

((several lines omitted in which respondent mentions, amongst other issues, that 'the anatomy is not all eh all clear because 'their background is is not eh enough'))

1175. I Not everyone understands completely [then
1176. R [No and that depends probably also on the
1177. intelligence of the of the people [you have to deal with.
1178. I [yah yah
1179. I Yah
1180. R If they are intelligent probably they understand very well if they are not,
1181. [(maybe) [(.) not at all [so
1182. I [okay [ya:h [yah
1183. I So there may be some misunderstandings which arise either due to lack of
1184. anatomical knowledge or intelligence which is not very high or that there are
1185. translations problems really
1186. R Yah I think so

Asked whether he sometimes experiences misunderstandings, the respondent acknowledges that 'there's a lot of misunderstandings' (line 1102, 1119). He makes himself not accountable for these misunderstandings, by attributing them, in various ways, to patients' lack of knowledge or intelligence. First, the respondent does this by making clear that his patients 'have no idea what problems they have' (line 1103), that 'they have heard of the womb, they have heard of the tubes but that's all what they he, what they know' (line 1104-1105). Hence, the respondent restricts his patients' knowledge to basic organs, like the womb and tubes. Second, the respondent portrays his patients' knowledge as limited by saying that 'lots of women they have no idea about wombs etcetera' (lines 1112-1113), and thus making clear that there are also many who do not know 'even' about basic organs. Note that the respondent's 'etcetera' (line 1113) implies that the lack of knowledge is extendable to an unspecified number of other organs or biological features. Second, the respondent provides an example of a particular patient (lines 1105-1107). He mentioned earlier in the interview that this patient refused an operation, in which a tumor would be removed, but which would also make her infertile. The respondent reiterates that she will die of cancer if nothing is done about it (line 1106-1107), and attributes the refusal to have something 'done about it' to the patient's lack of knowledge: 'probably she doesn't realize that he what it means' (line 1107-1109).[49] Noteworthy is the respondent's additional information that this patient speaks English (line 1109) and is therefore 'a bit educated' (line 1110). Thereby he implies that patients who do not speak English, and are less educated, will certainly lack knowledge needed to understand him adequately. Third, in lines 1115 to 1117, the respondent sets up a straw man argument. He states: 'although probably they slaughtered some animals' (line 1115), thereby suggesting that his patients could know about wombs because they slaughtered animals. However, the respondent subsequently makes clear that this experience is not sufficient: 'but the wombs of animals are different from wombs of eh people' (line 1117). Hence, the respondent

[49] Interestingly, the first time in which the respondents brings to bear this example, he attributes this example to the importance of bearing children in Malawi. This shows how utterances in interviews depend on the interactional context, which includes the questions asked, and the interactional issues which are at stake.

makes clear that his patients have insufficient knowledge, in this case regarding his work. By constructing misunderstandings as based on patients' lack of knowledge, the respondent makes himself not accountable for them.

Fourth, the respondent states explicitly that patients' understanding 'depends probably also on the intelligence of the of the people' (line 1176-1177) and that 'if they are intelligent probably they understand very well, if they are not, (maybe) (.) not at all'. (line 1180-1181). By means of the if-then construction (Potter & Edwards, 1992), the respondent constructs intelligence into a necessary and sufficient condition for understanding, and hence, makes lack of intelligence into a sufficient explanation for not understanding[50].

As mentioned, in interactions between western practitioners and their patients it is to be expected that misunderstandings arise due to the practitioner's inability to speak the local language. Indeed, the respondent makes this issue relevant: 'also because I don't speak the language' (line 1121). However, he subsequently constructs also the problems related to this inability in such a way that he is not accountable, or to blame for them. The respondent explains that his inability to speak the language can lead to misunderstandings due to the interpreter he uses: 'I have always an interpreter (…)and I'm not hundred percent sure if she tells what I'm telling the woman' (lines 1123-1125). This is another way in which the respondent can be seen to forestall that he is held accountable.

It appears then, that also when it seems reasonable to expect that practitioners themselves contribute in some way to problems encountered, such as communication problems, respondents can construct themselves as not accountable for problems in helping infertility clients.

9.4 Summary and Discussion

In this chapter, I have shown how practitioners, both indigenous healers and biomedical practitioners, persuasively acclaim their success in treating infertility patients, and make their success contingent on their own actions. In so doing, I have

[50] There are more respondents, including Malawian biomedical practitioners, who attribute communication problems to characteristics of their patients, such as lack of knowledge, intelligence or 'civilisation'.

argued, they make relevant their competence as health practitioners. In addition, respondents appear to forestall that their competence is doubted, by denying that their assistance disappoints patients and constructing problems in such a way that they are not held accountable for them. For instance, respondents attribute not curing infertility to their patients, that is to their physical make-up, (behavioural) dispositions, or lack of knowledge or intelligence. Respondents do this as well when accounting for communication problems, which could easily be seen as result of practitioner 'factors' such as inability to speak the local language.

The analysis made apparent certain differences between the way indigenous healers and biomedical practitioners account for successes and failures. Indigenous healers can be seen to make their success pertain to infertility patients in general, whilst attending to failures to solve fertility problems as pertaining to only certain instances. Biomedical practitioners construct successes as more limited, and not necessarily related to their own interventions, while attending to their inability to solve fertility problems as pertaining to dealing with infertility patients in general. I will return to this issue in the discussion chapter.

Other studies have found as well that (health) professionals attend to, defend and work up their success and competence in conversations. An example is Gilbert and Mulkay's (1984) seminal discourse analytic study of accounts provided by biochemists in journal publications and interviews. One of the observations which Gilbert and Mulkay (1984) make is that scientists account for their own and other scientists' work in such a way that their own work and findings appear correct, and others' erroneous. In other words, the scientists construct themselves as successful and competent scientists, as the health practitioners in my study can be seen to do (see also Coelho, 2005). Parry (2004) shows how physiotherapists account for patients' incompetence in such a way that the therapy they give is not invalidated. In so doing, they can be seen as construing themselves as successful, and as forestalling that their competence and expertise is threatened by the failings of their patients.

The observation that practitioners' competence is a relevant concern for them when accounting for success, failures and problems, can have practical consequences outside the interview context. For instance, similar concerns may inform their interactions with patients in consultations, or the accounts which they provide in

medical records, or interviews used for audits. I will elaborate on these issues in chapter 10.

The analysis presented shows also how success, failure and problems in health care, and the challenges which they pose for practitioners' expertise are, at least partially, negotiated. This has been argued by other authors as well. For instance, Waldram (2000) points out that traditional practitioners' 'success' and 'failures' are always negotiated between social actors, in particular between the healer and patient, who thereby bring into play their personal perceptions, experiences and motives. Lutfey (2005) shows in an interview- and observation based ethnographic study how practitioners' adopt certain roles in the prevention of non-adherence in diabetes patients, and use these stances to actively induce patients to adhere to treatment. Hence, Lutfey (2005) points out that physicians actively contribute to the phenomenon of non-adherence, and that their judgements of non-adherence should not be seen as passive assessments, straightforwardly reflecting their patients' behaviour.

Overall then, similar to the analysis presented in chapter 8, this chapter's analytic findings contribute to the argument that medical practices and views are of a fundamentally social nature. I have shown how health practitioners' constructions of successes and problems tie in with interpersonal issues at stake, like not being held accountable for problems and being seen as competent practitioners.

In the next chapter, I will summarize the main analytic findings of this thesis, evaluate the study, and discuss its theoretical, methodological, and practical implications, as well as suggestions for future research.

Chapter 10. Discussion and conclusions

The aim of this study was to gain insight into how people with a fertility problem, significant others, and (indigenous and biomedical) practitioners construct infertility, in Malawi. I examined constructions of infertility, its causes, solutions and consequences in interview data, which I analysed using discourse analysis and conversation analysis. This enabled me to examine the discursive devices which the different kinds of respondents employ in their constructions, and the interactional and interpersonal functions which their constructions fulfil. I paid special attention to what kind of normative and moral issues respondents attend to and manage, where relevant, as the literature suggests that these issues are pertinent to infertility (Dyer et al., 2002; Gerrits, 1997; Inhorn, 1994b; Riessman, 2005; Pashigian, 2002).

In this final chapter of the thesis, I will summarize the main analytic findings (section 10.1), discuss the methodological issues which this study raises (section 10.2), and evaluate the analysis (section 10.3). I will then discuss various contributions of this thesis; to methodological developments in conversation and discourse analysis, infertility studies, and to more general, interview based qualitative studies (section 10.4.2), to theoretical developments in health psychology and health promotion (section 10.4.3), and to practical attempts to alleviate the burden of infertility (section 10.4.4). I will end this chapter with a brief recapitulation of the study, and will suggest how this work can be taken forward.

10.1 Summary of the main analytic findings: Interpersonal, normative and moral issues

In the data examined, interview-respondents appear to manage various interpersonal matters when talking about infertility, in that they attend to others' judgements and inferences about themselves, which their statements can make available. The interpersonal concerns which respondents orient to, are predominantly of a normative and moral nature, in that respondents attend to various expectations about what they ought to do, and to potential judgements of their actions and themselves, as in some

way 'bad', or 'good'. These issues have not been discussed before in the literature on infertility in developing countries, or from a rather different perspective than mine, which focuses on constructions and the social actions which they fulfil. I will review the normative and moral concerns to which respondents attend in turn, although it should be borne in mind that most of them are intertwined.

10.1.1 Normative concerns

First, I have shown (see chapter 4) how respondents attend to, and construct, normative expectations regarding childbearing; certain people, in particular married people, young people or grown ups, 'ought' to bear children. Respondents accomplish this construction by using various discursive devices, such as references to the cultural context, if-then constructions, and scripting devices. This then, provides an alternative perspective on the notion of a cultural norm which prescribes procreation. Pronatalist cultural norms abound in the infertility literature (Dyer et al., 2002, 2004; Inhorn 1994, 2003; McDonald Evens, 2004, Riessman, 2000a, Sandelowski, 1988), and many scholars appear to treat them as explanations for the problematic nature of infertility. There is therefore a tendency to reify these norms into independent cultural 'facts', responsible for the pressure on people to reproduce, and the hardship involved when people fail to do so. [51] The problems with this conceptualisation of 'culture' as set of prescriptive rules, which makes people into 'cultural dopes' has been pointed out by Garfinkel (1967) and various other scholars (Heritage, 1984; Shotter, 1984, 1993; Wittgenstein, 1953). By contrast, my approach draws attention to the active involvement of people in the situated construction and reproduction of cultural norms. As I will discuss in more detail in the next section, one of the benefits of such an approach is that it brings to light the functions which such constructions can fulfil, which can have useful practical implications (see section 10.3.3).

[51] Such an approach to 'culture' and 'norms' as reified 'agents' is commonly adopted, also in research on various other health issues in developing countries. For instance, two reports related to sexual and reproductive health in Malawi (Moser, M'chaju-Liwele, Moser, Ngwira, 2003; Matinga & McConville, 2002) draw attention to the importance of cultural norms and beliefs, which lead to cultural practices which constitute 'unhealthy' or 'risky' behaviours. As Jeffery, Jeffery & Rao (forthcoming) note, attributing health problems, or behaviours leading to them, to people's 'culture' can constitute an undesirable form of victim blaming, which diverts attention away from how (health) professionals can contribute to problems, as well as prevent and help solving them.

Second, men and women with a fertility problem attend in several ways to not taking action as a problematic breach of normative expectations. Hence, they appear to take into account the idea that they ought to take action in order to solve their fertility problem. Such normative orientations may inform people's relentless search for solutions, frequently reported in the literature on infertility in developing countries (Berer, 1999; Inhorn, 2004, 2003; Sundby, 2002).

Third, indigenous and biomedical practitioners can be seen to attend to normative expectations concerning the actions of competent health experts. I have shown (chapter 9) how practitioners persuasively construct themselves as successful, deny that this disappoints patients, and construct themselves as not accountable for failures and problems in helping patients. In so doing, they can be seen to draw upon ideas that 'proper' illness experts ought to be able to cure infertility and to help patients, and not 'cause' problems.

I have mentioned (chapter 9) that indigenous healers construct their successes as pertaining to infertility patients in general, whilst relating failures to solve fertility problems to specific instances. Biomedical practitioners however, construct their successes as concerning specific cases, and attend to their inability to solve fertility problems as pertaining to infertility patients in general. Tentatively, I would like to suggest that this discrepancy may be informed by a difference in the nature and status of indigenous healing and biomedicine. Overall, indigenous healing receives much scepticism and scrutiny from those with a western biomedical training. Some indigenous healers appear to attend to this difference in status, for instance by emphasizing that they have been trained by the hospital or that they refer patients to the hospital[52]. In addition, indigenous healers', but not biomedical practitioners', employment is dependent on the clientele they can attract. This makes being seen as successful more important for healers. The different nature and more dubious status of indigenous healing may mean that indigenous healers, unlike biomedical practitioners, cannot afford to come across as successful in only certain cases. However, this suggestion requires further examination, in particular by examining participants' own orientations regarding the status of their profession.

[52] They do this in interview extracts not discussed in this thesis

A fourth set of normative expectations to which respondents attend concerns medical knowledge. To begin with, when designing claims about causes of infertility as persuasive in repsonse to mild challenges (see chapter 8), indigenous and biomedical practitioners appear to attend to the idea that illness experts ought to know the facts about causes. Respondents design their claims as persuasive for instance by using verbs like 'must', if-then constructions to establish the connection between a proposed cause and infertility as certain, and by providing empirical observations as supportive evidence. In addition, practitioners attend to the basis of their claims. In so doing, they can be seen to attend to the notion that in principle, expert knowledge ought to have an appropriate basis, in particular, that claims ought to be derived from category bound activities, such as testing, calculating and reading scientific literature. Furthermore, I have shown (chapter 8) that biomedical practitioners' claims about non-biomedical causes are ambiguous and non committal, and that they attend to a conflict between acknowledging non-biomedical causes and their biomedical expert identity. In other words, biomedical practitioners can be seen to orient to normative ideas that proper medical experts do not acknowledge non-biomedical causes.

Unlike practitioners, lay respondents can be seen to take into account a lack of entitlement to knowledge in their constructions of causes (chapter 5), when they emphatically deny knowledge of causes, design their claims as ambiguous and non-committal, and make others relevant as the source of their knowledge. This notion that lay respondents ought *not* to know about causes may also inform denials of knowledge and ambiguity in claims regarding causes of illnesses, observed in several other studies of infertility (Dyer et al., 2004; Gerrits, 1997), and other health issues (Joshi, 1995; Steen & Mazonde, 1999). Often, not much attention is paid to these observations. My analysis shows how they can be understood as 'functions' of interpersonal concerns, such as a lack of entitlement to knowledge. This has methodological and theoretical implications for common approaches to illness cognitions and health seeking behaviour, as I will address in later sections.

10.1.2 Moral concerns

A first moral concern which respondents manage features in their constructions of practices such as extramarital affairs and polygamy. Respondents justify people's engagement in practices such as extramarital affairs and polygamy when no children are born, by making them into culturally required, routine, and practical solutions, and by denying people's agency in these practices. Hence, respondents draw upon cultural normative expectations to manage and forestall potential moral judgements of certain practices, such as extramarital affairs and polygamy.

Second, respondents can be seen (chapter 6) to attend to moral judgements which a breach of expectations regarding taking action may invoke. I have discussed several ways in which respondents play down their culpability for not taking actions, in several ways: they make clear that they have tried to take action, and (thus) to be, in principle, motivated to do so; they play down their responsibility for their inaction by attributing it to barriers external to themselves (e.g money, other people); and they construct inaction as a reasonable decision.

Third, respondents appear to deal with moral issues when identifying causes of infertility. I have shown how respondents, after identifying STDs or abortions as potential causes of infertility, forestall the inference that they themselves are infertile because of these causes. I have suggested that this may be due to negative 'immoral' connotations of contracting STDs and abortions.

The relevance of such moral judgements for claims about causes, sheds light on findings reported by Gerrits (1997). She mentions that although many of her Mozambiquan respondents identified STDs as cause of infertility, and had had a STD themselves, none of them related it to their own infertility. My analysis suggests that this may be informed by potential, morally problematic consequences of being seen as infertile due to STDs. Like the normative issue of lack of entitlement, the relevance of moral judgements has implications for the status of people's claims about causes, as I will discuss in sections 10.3 and 10.4.

Furthermore, biomedical practitioners also deal with moral concerns related to identity issues. I have shown how biomedical practitioners avoid dismissing non-biomedical causes, for instance by reframing them as psychological factors. I have suggested that this can be seen as a strategy which forestalls that practitioners are

cast in a morally problematic identity category such as ethnocentric white doctor, or 'improper' cultural member.

A fourth and last set of moral concerns is made relevant in constructions of relationships. Respondents construct their relationships as good, play down the significance of spouses' extramarital affairs, and avoid complaining about, or blaming others for relationship troubles (chapter 7). I have suggested that complaining and blaming in this context are sensitive issues, as they may invoke moral judgements regarding the respondents themselves. Respondents may be seen as being to blame themselves for relationship trouble, or may be judged negatively when complaining about or blaming spouses, relatives or fellow community members.

In some other studies, the responses of some participants appear to fulfil a similar function of 'not blaming' spouses, relatives or community members for relationship troubles (Dyer et al., 2004; Gerrits, 1997; Gerrits et al., 1998; Riessman, 2000). Nevertheless, men and especially women are normally portrayed in the literature as suffering from, and thus victims of social exclusion, accusations, stigmatisation and abuse (Dyer et al., 2002; Gerrits, 1997; Sundby, 1997; Inhorn, 2004; Mariano, 2004; Neff, 1994; Riesman, 2005, 2000). These descriptions denote that hardship is inflicted upon people with a fertility problem by others, who are thus to blame. Thus, as argued in chapter 7, it appears that although authors' glosses may fulfil a laudable political function of giving voice to infertile men's and especially women's suffering, they may not be in line with people's own constructions of relationships and relationship trouble, and the moral concerns they thereby attend to (cf. Widdicombe, 1995). Therefore, these constructions and concerns, and how they may be triggered by the questions asked, require more attention.

This is so, in addition because the literature portrays extramarital affairs and other forms of marital instability as one of the main hardships which women with a fertility problem must endure. However, my analysis suggests that it should be taken into account that certain practices, for instance extramarital affairs or polygamy, are not necessarily treated by people themselves as indicative of the bad quality of their relationship.

As mentioned in chapter 7, I would like to emphasize that I do not mean to say that being (seen as) infertile is less problematic than is suggested elsewhere. First, discourse analysis and conversation analysis do not enable one to obtain insight into people's experiences, and thus I cannot make claims about the extent to which people experience hardship or not. Second, not blaming others or playing down the significance of extramarital affairs can be problematic in itself, as it would seem that this makes it more difficult to 'speak out' or 'stand up' against the relationship troubles experienced (see also section 10.3.4).

10.1.3 Overarching insights

Two overarching insights can be distilled from the above summary of the findings. First, my exploration of respondents' situated orientation to, and invocation of, normative concerns provides insight into what explicit or implicit references to the normative nature of practices can mean 'for all practical purposes' (Garfinkel, 1967). When practices in foreign cultures are studied, it is common to label them as 'normative', or 'cultural', or both (see e.g. Moser, M'chaju-Nwele, Moser & Ngira, 2003; Matinga & McConville, 2002), as happens with childbearing in infertility studies. However, this is a rather vague, opaque label, which needs further unpacking. I have been able to show how cultural or normative expectations are resources, available for use. To begin with, they can be used to justify certain practices, such as when respondents appeal to the cultural requirement of bearing children in order to justify people engaging in extramarital affairs or polygamy. In addition, respondents draw upon normative expectations regarding practices, typical for certain categories of people, in order to work up an identity. For instance, practitioners attend to expectations that they are successful and perform certain activities, such as testing and calculating, and thereby bolster their identity as competent illness experts. Hence, I subscribe to Kitzinger's (2006) claim that providing insight into the invocation of mundane understandings regarding what is normative, and hence the situated (re)production of culture in interaction, is one of the strengths of discourse and conversation analysis, and should be developed further.

Second, as I have shown that both lay respondents and practitioners attend to normative and moral issues, my analysis contributes to insights into the social nature of medical practice. So far, the focus has mainly been on how practitioners' practices and views are informed by the 'macro' cultural context (Finkler, 2004; Lock, 1988), or on their normative and moral consequences for people with a fertility problem (Pfeffer, 1993; Sandelowski, 1990; Malin, 2003). Inhorn's (1994) study is different, in that she discusses how medical practice is informed by practitioners' interests. However, she does not examine whether and how practitioners themselves attend to those interests. My analysis brings to light interpersonal, normative and moral matters at stake for the practitioners themselves, to which they attend in concrete, actual, situated interactions.

10.2 Methodological issues

My study raises several methodological issues, related to the use of interview data, interpreters and translators, and quantification. I will discuss these issues in turn.

10.2.1 Interview data

In chapter 3, I pointed out that conversation analysts, and, increasingly, discursive psychologists, have a 'dispreference' for interviews (Hutchby & Wooffitt, 1998; Speer, 2002). Interview data are seen as biased by the researcher's agenda and analytic ideas (Potter, 2004b; Ten Have, 1999, 2002b), which leads participants to provide normatively appropriate descriptions by the participants (Potter, 2002). I argued that as this argument relies on participants orienting to the situation as specifically 'being in an interview', the best strategy seems to be to stick to the criterion of procedural consequentiality (Schegloff, 1991; 1992). Hence, interview data should be treated as ordinary conversations, *unless* it is observable that and how respondents attend to the situation in the specific extracts as 'being in an interview' (Widdicombe & Wooffitt, 1995). On some occasions, participants and in particular interpreters could indeed be seen to attend to the situation as an interview. This happens for instance when a respondent points out that a question has already been asked before, and the interpreter tells him 'yes, but you have to repeat where

necessary'[53]. In this instance, respondent and interpreter attend to the situation as not an ordinary conversation, but one with a predetermined, uni-directional (i.e. the interviewer asks, the respondent answers) question-answer format. However, these orientations to the interview situation are rare.

Another way in which the interview situation would be procedurally consequential, is if respondents treat me in terms of my interviewer identity, rather than in terms of the many other identities according to which I could be treated, such as woman, westerner, or academic. Interestingly, in several instances, respondents treat me as a medically informed person, for instance when respondents with a fertility problem ask for advice about what to do about their fertility problem, or when indigenous healers asked about how to cure certain illnesses. In addition, as I will discuss in the next section, at times, respondents or interpreters took into account my status as foreigner. However, although at times some of the identity categories to which I could be allocated are procedurally relevant, this was normally not my identity as interviewer.

Therefore, the interviews which I conducted can be treated as 'natural-interaction-in-interview' (Potter, 2004b, p.9) and exhibits of culturally shared accounting and reasoning practices (Silverman, 1985; Wooffitt & Widdicombe, 2006), which are at least potentially generalizable to situations outside the interview context (see section 10.3 for further reflections on generalizability). Moreover, as I will explain in the next section, in studies like this one, conducted in and pertaining to a foreign context, interviews are a particularly useful, if not necessary, method of data collection.

10.2.2 Cultural context

As explained in chapter 3, conversation analysts normally do not rely on information about the external, cultural context in which conversations occur. It is argued that context should only be taken into account when it is 'procedurally consequential', that is when it is observable that, and in what way, conversation partners design their talk according to certain contextual features (Schegloff, 1991, 1992; ten Have, 1999b). When interactants belong to different cultural-linguistic communities, it

[53] This quote is from an extract not shown in this thesis

seems likely that the analyst lacks certain cultural knowledge and competence, necessary for analysis (ten Have, 1999b; Wong & Olsher, 2000). Using interview data, in which the interviewer belongs to a different cultural community than the other participants, appears to be one particularly suitable way to remedy such lack of cultural knowledge (de Kok, 2004). This is so, first, because such interviews can function like Garfinkel's (1967) 'breaching' experiments, in which taken for granted assumptions and sense making practices are breached, and therefore made visible and available for analysis (see chapter 3). The interviews accomplish a similar breaching effect, due to the interviewer's questions about issues which normally might be taken for granted by the 'members', and would otherwise not be explained, or referred to only in highly implicit ways.

Second, according to the principle of recipient design (Sacks & Schegloff, 1979), interactants design their utterances in such a way that they are understandable for a particular speaker with a certain presupposed knowledge (ten Have, 1999; cf. Haywood, Pickering & Branigan, 2005). Therefore, it is to be expected that participants will, at times, have provided more information[54] than they would have done in interactions with fellow cultural members.

Hence, using interviews is one, particularly suitable, way to deal with the analyst's lack of cultural knowledge, as participants themselves bring to bear cultural information 'there and then'. Consequently, there is no need to look elsewhere for ethnographic data about the context, and one can avoid invoking contextual information, which may seem relevant to the analyst but does not necessarily tie in with the orientations of the interactants themselves.

This principle of recipient design may be especially pertinent to interactions mediated by an interpreter. Wadensjö (1998) has pointed out that the task of interpreters is to promote a shared understanding, rather than merely translating. Fulfilling such a task may require filling the gaps in the interviewer's cultural knowledge. Indeed, in several extracts the interpreter provides additional contextual information, or explicates the upshot of what the respondent says. For instance, in

[54] Note that I suggest that participants will provide *more* information, or that they will be *more* explicit; for reasons discussed before (chapter 3 and section 10.2.1, this chapter) it seems unlikely that they draw upon understandings and normative notions which pertain specially, and only, to the interview situation.

chapter 5, extract 6, the respondent mentions 'girls initiation' (lines 843-850). In her translation, the interpreter does not use the same term, and provides additional information: 'in African countries, people- especially girls, are taken to go somewhere else and be advised.' (lines 860-864). Hence, the interpreter can be observed to take upon herself the task of being a cultural translator by adding cultural information to the respondent's answer.

Although the presence of an interpreter seems to have benefits for the analysis, it also evokes some methodological problems. I will address these in the next section.

10.2.3 Issues of language, interpretation and translation

In chapter 3, I introduced several language-related issues which my study raises. First, participants' non-native speaker status means that what respondents say and how they say it, depends on participants' limitations in fluency, as well as on the interpersonal and interactional issues at stake. However, in chapter 3 I have discussed several analytic strategies which I have adopted, which limit the relevance of participants' fluency for the analysis.

Second, interpretations, like any kind of translation, are active re-constructions of what was originally said, rather than a neutral 'passing on' of the message (Riessman, 2000; Temple, 1997; Pitchforth & van Teijlingen, 2005; Venuti, 1998; Wadensjö, 1994). This is less of a problem for a study like mine, which is based on a relativist epistemology and aims to examine the situated co-construction of meaning, than for researchers who adopt a realist perspective and treat statements as pathway to an objective reality 'out there', or in people's minds. In my study, I obtained translations of the interpreter's utterances, for the extracts which I used in the final analysis. This enabled me to see what the interpreter omits from, adds to, or changes in, the respondent's and interviewer's utterances, and how they thereby contribute to the production of meanings and actions. In this way, the interpretation formed a useful tool to obtain insight into inferential and interpersonal issues at stake, rather than an impediment to analysis (cf. Wadensjö, 1998).[55] For instance, in chapter 5 I have shown how interpreters treat respondents' denial of knowledge

[55] See section 10.2.1 for other benefits of the interpreter

about causes of infertility as 'reluctance to tell', in part by repeating questions about causes, or by encouraging respondents to 'feel free'. These observations, and others (e.g. regarding the non committal design of responses), suggest that identifying causes is a sensitive issue for respondents.

It has been suggested that researchers should discuss the interpreter's or the translator's social position (Temple, 1997), in order to be able to examine how characteristics such as educational background, life experiences, or beliefs may have affected the production of the translated text. However, like the relevance of the interviewer's identity as interviewer, the relevance of the social position, or identity of the interpreter, should be treated as an empirical question. Like interviewers, interpreters are categorizable in various ways. In the interview extracts which I examined, I have not been able to observe that interpreters or respondents attend to the interpreters' identity as, say woman or man, or health surveillance assistant. In other words, I have not been able to establish that interpreters' identities were procedurally consequential for respondents' talk. Although I do not see this as a guarantee that interpreters' social positions did not matter for respondents' utterances, there seems to be no firm basis for assuming that characteristics of the interpreter influenced the data in some systematic way.

The criterion of procedural consequentiality (Schegloff, 1993) cannot be employed to gauge the relevance of the translators' social identities for their translations and data 'production'. These could matter for instance if identities, such as those based on religious affiliation, make translating certain phrases, such as those about extramarital relationships or sexual activities, rude or improper. This is one of the reasons why the third language issue, the contribution of the translators to the production of my data, poses a greater problem. It makes that the analysis is, even more than normally, not based on the 'thing-in-itself'.

However, I have adopted several strategies which minimize any systematic distortion. First, I have used several translators of diverse backgrounds (female and male, students in linguistics and nursing at universities in Malawi and in Scotland, and professional translators). The variety in translators will, to some extent, have prevented a systematic 'bias' in the translations. Second, all translators which I used belonged to the same ethnic group as the respondents and interpreters whose

interactions they translated. It has been argued that in order to obtain 'conceptual equivalence', or comparability of meaning, in translations, translators need to have 'intimate' knowledge of a culture (Frey, 1970; Warwick & Osherson, 1973). Considering their ethnicity, it can be expected that the translators whom I used had the necessary cultural competence. Third, I asked translators to put additional information or interpretations in brackets, when they thought that literal translations might make certain sentences or passages difficult to understand for me. While these interpretations and information appeared seldom necessary for the analysis, they enabled me, to some extent, to literally 'bracket' translators' interpretations. Fourth, analytic claims are normally based on a variety of extracts from both translated and un-translated interviews, that is interviews which were conducted in English. Exceptions are claims which pertain specifically to the indigenous healers, as these were all conducted with an interpreter.

Overall, it seems that although issues of language, interpretation, and especially translation make my claims somewhat more tentative, they do not make the data 'unworkable', or my claims unfounded. This is so in part because of the strategies I adopted, due to certain features of the translators, and because my study is based on a relativist epistemology and an analytic tradition which has a strong interest in, and sees as inevitable, the co-production of meaning by interactants, *including* interpreters.

10.2.4 Quantification

In three analytic chapters, I provided counts in order to support analytic claims. This is unusual in qualitative research, including discourse analytic and conversation analytic studies. Nevertheless, several authors have argued that a commitment to constructionist research, or qualitative research in general, does not necessarily imply a commitment *against* counting (Potter, 1996; Sandelowski, 2001; Silverman, 2000; Dey, 1993). However, counting should be done only in order to support analytic observations rather than as an aim in itself (cf. Hutchby & Wooffitt, 1998) and only when meaningful for the analysis (Hakaana, 2002; Sandelowski, 2001; Schegloff, 1993). For instance, counting in qualitative projects could be useful in that it gives a reader a feel for the data as a whole (Silverman, 2000), and (thereby) makes patterns come out more clearly (Dey, 1993). This is indeed the way I have used counts: to

support observations regarding patterns in accounting practices, that is differences observed between types of respondents (e.g. those with and without children, or indigenous healers and biomedical practitioners).

Schegloff (1993) points at another requirement of meaningful quantification: it needs to be built on the back of detailed case-for-case analysis (Haakana, 2002; Hutchby & Wooffitt, 1998). This is so, first, because counts should be based, as much as possible, on participants' own categories and orientations (cf. Hutchby & Wooffitt, 1998; Schegloff, 1993; Silverman, 2000). The counts which I have provided pertain to categories which stay close to respondents' own terms (e.g. 'claims success' and 'accounts for, or explains, not taking action') rather than to abstract theoretical categories (e.g. 'internal locus of control'), which are potentially of little relevance for participants themselves.

Second, analysis is needed in order to be able to decide what 'counts' as the phenomenon under investigation, or the actions which speakers perform in talk, as this requires insight into the various ways in which actions can be achieved (Schegloff, 1993). I have made various decisions about what counts as 'in-action', 'indicates success' or 'indicates failure', on the basis of analysis of the individual cases. For instance, I excluded references to practitioners' ability to 'help' infertility patients in ways other than solving their fertility problem, such as informing them about the cause of their infertility, or providing reassurance. Such responses appeared to fulfil the function of not coming across as useless, but were not designed as displays of being successful in treating fertility patients.

Third, if one wants to make claims regarding the frequency of phenomena in terms of proportions (i.e. an action occurred x out of y times), one needs to analyse individual cases for whether and when the phenomenon *could* have occurred, that is whether performing a certain action was possible and relevant (Schegloff, 1993). I have taken into account 'environments of possible relevant occurrence' (Schegloff, 1993, p. 103), in that for instance in chapter 9, the count of general or specific claims of success and failure is only based on interviews in which practitioners could reasonably address issues of success or failure in helping infertility patients. Hence, I excluded interviews in which practitioners, such as health surveillance assistants,

made it clear that they do not treat people with fertility problems and only refer them to other practitioners, as their ability to solve fertility problems was not a relevant issue. [56]

It should be clear then, that the counts provided are based on decisions, which could have been taken in other ways. Nevertheless, I feel that the counts are sufficiently grounded in participants' orientations and detailed analysis, in order to be useful heuristic tools which support observations regarding patterns in the data.

10.3 Evaluation of the analysis

Evaluating discourse analytic studies is not a straightforward matter (Taylor, 2001). Discourse analysis is based on a relativist, constructionist epistemology. Therefore, instead of adhering to the realist, positivist assumption that there is one reality 'out there', to be revealed through proper use of scientific methods, discourse analysts consider research 'findings' as inevitably, at least partially, constructed by researchers, in interaction with participants (Madill, Jordan & Shirley, 2000; Willig, 2001). Consequently, several authors have argued that the standard criteria of objectivity, validity (i.e. research findings should represent the 'truth') and reliability (i.e. another researcher, using the same methods should obtain the same findings) have to be adapted, or replaced. This will enable the evaluation of discourse analytic studies in a way which fits in with its epistemological basis (Elliott et al., 1999; Madill et al., 2000; Taylor, 2001; Willig, 2001). Various new criteria have indeed been developed in order to assess the quality of discourse analyses (Potter & Wetherell, 1987, Potter, 1996a; Taylor, 2001), which I will use for the evaluation of my analysis.

10.3.1 Evaluation of the analysis in terms of new criteria

To begin with, Antaki, Billig, Edwards and Potter (2003, p.2) have identified six pitfalls, or forms of 'under-analysis', which ought to be avoided in order for discourse analysis to be rigorous. My analysis satisfies their recommendations. First of all, I have avoided merely summarizing the (content based) themes which can be

[56] I also excluded interviews which were not translated from the counts.

identified in data, which leads to a loss of information (Antaki et al., 2003). Instead, I have always added information, by detailing the discursive devices used, how certain constructions are built, and how these constructions function. Second, I have avoided 'isolated quotation' (Antaki et al., 2003), in which quotations are divorced from their context, and left to stand for themselves. I have provided full sequences, normally starting with a question by the interviewer which initiates a topic or question, and following through the interaction until a next topic or action was initiated, usually by means of a next question by the interviewer (Pomerantz & Fehr, 1997). In addition, as I discussed analysis of the extracts in detail, they were certainly not left to speak for themselves. Third, I have avoided under-analysis through 'circular discovery' (Antaki et al., 2003). For instance, I have not inferred the existence of a cultural norm, for instance regarding childbearing, from respondents' expressions, and subsequently used this norm to explain respondents' expressions or actions from which the 'norm' was inferred in the first place. Fourth, I have done more than merely 'spotting' discursive devices in the data which have been identified in other studies; I have explained how respondents exactly use these devices *in situ*, in order to manage the interactional business relevant for them. Fifth, I have not engaged in what Antaki et al. (2003) call a 'false survey'; I have not treated findings as generalizable to the other members of the categories to which I as analyst could allocate the participants to, such as 'middle aged male with fertility problem, belonging to Tumbuka ethnic group'. This is not to say however, that I withhold any claims regarding the generalizability of my analysis, as I will discuss in more detail below.

Sixth, I have not substituted detailed analysis for 'taking sides'. Antaki et al. (2003) point out that analysis should not be led by the aim of evoking the reader's sympathy for, or condemnation of, a certain phenomenon, as this can lead to a simplification of the discursive complexity in what was said. It should be noted that Antaki et al.'s (2003) caution does not pertain to taking sides in itself. They appear to adopt a stance, common for conversation analysts (Wetherell, 2001): any critical or political interrogation of the data, ought to be carried out *after* rigorous analysis of data 'in its own terms' has taken place. I have indeed adopted a particular position myself; in particular in the introduction, I have made a case for the need to pay

attention to infertility, highlighting that infertility in developing countries is a serious problem at both a personal and public health level. I will develop this stance further in this discussion chapter. However, I have, as much as possible (see Burman, 2002), not let my personal position drive the analysis, basing analytic claims instead on the actual details of the interactions and, most importantly, participants' orientations. Note that the qualifier 'as much' is important. I want to avoid the overly empiricist stance which conversation analysts have been accused of because of their emphasis on the possibility and importance of making theory-less, disinterested, direct observations regarding the organisation of conversations (Atkinson, 1988; Lynch & Bogen, 1994, cf. Hammersley, 2003). Inevitably, analytic claims are not merely based on neutral, direct observations of 'what is there'; my analysis of the interactions will have been led as well by my own analytic and personal interests and presuppositions (cf. Coelho, 2005; Wetherell, 2001).

In addition to this outline of pitfalls to be avoided in discourse analysis, criteria for analysis have been framed in more positive terms. A first criterion is basing claims on participants' understandings or orientations, as displayed in their utterances (Potter, 1996b; Potter & Wetherell, 1987). Second, analyses ought to be coherent (Potter, 1996b; Potter & Wetherell, 1987). This means to begin with that analytic claims should hang together well and should not be contradictory (Madill et al., 2000; Potter & Wetherell, 1987). Each of my chapters has a story to tell, and these stories all tie in with a larger narrative regarding the relevance and management of interpersonal, normative and moral issues in talk about infertility in Malawi. In this sense, my analysis is coherent. In addition, throughout the analysis I have taken into account deviant cases, that is, those which do not fit in with identified patterns. This is deemed important for achieving coherence (Potter & Wetherell, 1997; Potter, 2004b). As Potter and Wetherell (1987) recommend, I have adjusted my claims when they did not fit in with certain extracts I encountered, unless some features, as made relevant by participants themselves, could be identified which made these extracts clearly different from the others. For instance, I have pointed out in chapter 6 that three respondents did not account for their claims that they did not take action. However, these were all respondents who had one or more children. Therefore, I treated these extracts as not contradicting my claims regarding the displayed

preference to take action, although they suggest that this pertains especially to those people without any children.

Furthermore, as Potter (2004; 2006b) points out, analyses are coherent if in line with, and building on, other CA or DA studies. I have noted that respondents use various discursive devices, such as extreme case formulations (Pomerantz, 1986), or scripting devices (Edwards, 1994; 1995), in similar ways as have been identified in other discourse analytic and conversation analytic studies. In addition, respondents perform similar actions, in comparable ways, as observed in other studies. For instance, in chapter 5, I have pointed out that respondents attribute their knowledge to third parties. This has been found to be a strategy, used by lay people to deal with a lack of entitlement to medical knowledge, in other studies as well (Drew, 1991; Gill, 1998). These similarities between devices used, the way they function and the actions which speakers thereby engage in, lend more credence to my claims.

A third criterion which has been proposed is reader evaluation (Potter, 2006a; 2004); presentation of the very extracts to which analytic claims pertain enables readers of studies, like mine, to judge for themselves whether my claims are convincing and valid.

Fourth, analysis can be evaluated on the basis of its fruitfulness (Potter & Wetherell, 1987; Taylor, 2001); analysis ought to generate novel explanations, insights and solutions for problems in a particular field of research. Since my doctoral research is the first study of infertility which uses discourse analysis and conversation analysis, it has led to various new observations and insights in constructions of infertility and the management of interpersonal, in particular normative and moral issues, as discussed in section 10.1. They have various methodological, theoretical and practical implications (see section 10.4), and open up new avenues for enquiry. Hence, my study is fruitful (see section 10.5).

Overall then, the analysis presented in this thesis is rigorous, in that it satisfies several criteria which have been developed specifically for discourse analytic work. This lends credence to my analytic claims. In the next section, I will discuss their generalizability.

10.3.2 Generalizability

Generalizability, or the degree to which the results of a study can be extrapolated to other circumstances, is not normally seen as an evaluation criterion of discourse analytic research. Nevertheless, it is an issue of importance, in particular if one is interested in, as Potter and Wetherell (1987, p.174) recommend, 'the practical use of [one's] work over and above the amassing of researching findings and the furtherance of careers'.

The generalizability of discourse analytic research, as of qualitative research in general, is normally seen as highly limited, in particular due to its reliance on relatively small, non-random samples (Bryman, 2004). However, although the statistical generalizability of discourse analytic studies may be limited, there appears to be scope for their theoretical generalizability: findings may generate theoretical propositions which are generalizable (Bryman, 2004; Willig, 2001; Yin, 1994). Discourse analysis provides insights into how discursive constructions function in certain social, or more specifically, interactional contexts. It may be possible to generalize such 'theoretical' insights regarding the functions of constructions to similar social and interactional situations: insights into how constructions can deal with certain interactional and interpersonal issues raised by the social situation, should be transferable to comparable social situations. With 'comparable' I mean situations which are likely to raise similar interactional and interpersonal issues. For instance, in chapter 6, I have shown how identifying causes of infertility appears problematic due to participants' lack of entitlement to knowledge about causes. It therefore seems likely that these questions will raise a similar interactional problem, and may be dealt with in similar ways, when patients address their ideas about the cause of their fertility problem in consultations. In this case, the potential theoretical generalizability is backed up by the findings in several others studies that lay people attend to a lack of entitlement regarding medical knowledge in consultations (Gill, 1998; Drew, 1991), and also in conversations with other lay people (Drew, 1991).

It is worth noting that it is conceivable that respondents encounter many of the kinds of questions asked in the interviews in their daily lives (cf. Gillies & Willig, 1997). For instance, research participants in both my study and in other studies (e.g. Riessman, 2000, 2002) indicated that relatives or neighbours regularly

question them about the causes of their fertility problem by asking 'what is wrong with them', or ask about the kind of actions they are taking to solve their problem. It is conceivable that practitioners will be asked about their successes and failures, by patients, colleagues or those concerned with their evaluation. This pleads in favour of the potential generalizability of the insights gained. However, whether or not participants attend to similar concerns, and engage in similar actions, in other social situations will always have to remain an empirical question, answerable only on the basis of concrete observations in those situations.

Another argument regarding how it may be possible to generalize this study's insights is that discourse analysis focuses on how interaction partners use culturally shared understandings and methods of making sense. These are therefore in principle available in the culture or society, making insights gained potentially generalizable to other cultural members (Taylor, 2001; Widdicombe, 1993; Willig, 2001). Taylor (2001, p. 25) points out that in this argument, 'culture' is loosely defined, and does not necessarily mean a distinctive national culture or 'neatly bounded' grouping. This raises the question however, to which cultural groupings one's findings and insights can be exactly generalized (cf. Hammersley, 2003).

Thus, although there are several reasons why the findings of my study are at least potentially generalizable, no prediction can be made about the *exact* situations or members to which insights will apply. However, this does not appear to be an issue particular to this study, to discourse analytic research, or qualitative research in general. As some scholars have argued, the generalizability of a study can never be fully determined in advance, and to some extent, researchers will always have to explore and judge themselves whether and to what extent the study's findings can be transferred to other populations and contexts (Alasuutari, 1995; Seale, 1999; Taylor, 2001; Wetherell et al., 1998).

At this moment, a reflexive 'note of caution' seems in place. As Willig (2001) points out, discourse analysts' assumptions that language is constructive, implies that the researcher necessarily obtains the role of the author of the study, actively contributing to the construction of the research 'findings', rather than a mere witness or discoverer. By implication, this thesis, as any (academic) text, could be examined for the rhetorical techniques which I used, in order to make the analysis

convincing (cf. Potter & Wetherell, 1987). Hammersley (2003) points out that few discourse analysts actually engage in such a de-construction of their own writings. Although Hammersley (2003) therefore accuses discourse analysts of being inconsistent and of 'ontological gerrymandering', there are pragmatic reasons for not engaging in a detailed reflexive analysis of one's own work (Nicolson and McLaughlin, 1995; Potter & Wetherell, 1987; Wetherell, 2001). As Nicolson and McLaughlin (1995, p.116) explain, the aim of social constructionist studies is normally to provide insight into the constructed nature of *others'* claims rather than one's own, and 'it seems good practice to do either one or the other, and not both simultaneously'. Similarly, Potter and Wetherell (1987, p.183) point out that 'the most practical way of dealing with this issue is simply to get on with it, and not to get either paralysed by or caught up in the infinite regresses possible'. Hence, also I will leave, out of practical considerations, such a rhetorical analysis for a future project.

However, I do want to acknowledge that the analysis presented is one of various 'readings' of the data which could have been presented (Willig, 2001). Note that I am not claiming that *any* other interpretation could have been put forward. I have shown that my analysis obeys various criteria, according to which the analysis is rigorous and credible, rather than idiosyncratic or subjective. Nevertheless, I could have chosen to focus on different action-themes, which could have led to a selection of different extracts. Therefore, I subscribe to Stainton Rogers' (1998, p.10) remark: 'I am not, then setting out to 'tell it like it is, but rather saying 'look at it this way''. I have intended to provide one particular, alternative perspective on infertility and its management, regarding the interpersonal, normative and moral issues it evokes. Although not leading to the one and only 'truth' about infertility and its management, this perspective appears to be useful (cf. Nicolson and Mclaughlin, 1995); it leads to insights which form various valuable contributions, as I will discuss in the next section.

10.4 Contributions & implications of the thesis

10.4.1 Contributions to methodological developments

My study has several methodological contributions to make. First of all, the respondents in my research use various discursive devices which have been observed

in other CA and DA studies. This is noteworthy, as the vast majority of these studies has been conducted in western contexts. Therefore, this study demonstrates the cross-cultural relevance of at least some of the discursive devices identified in the discourse and conversation analytic literature. A second, related, methodological contribution is that my study suggests that CA and DA can be fruitfully employed when analyzing data from other cultures, as others have also argued (d'Hondt, 2002; Moerman, 1988; Wong & Olsher, 2000).

Third, this study can be seen as a plea for the usability of interviews, in particular when conducting research in foreign contexts (see section 10.2.1). As such, it forms a counter argument against the 'dispreference' for interviews, which has been present traditionally amongst conversation analysts, and is growing amongst discourse analysts, at least those belonging to the discursive psychology tradition in the United Kingdom (Edwards & Potter, 1992).

A fourth methodological contribution pertains to infertility studies, and more in general, to interview-based qualitative research. My study demonstrates the value of analysing in detail what people say, the concerns they thereby attend to, and how this is informed by the interactional context, including the questions asked (Wooffitt & Widdicombe, 2006). Such an analytic approach is all the more important for scholars looking at infertility in developing countries. One of their main aims seems to be to 'give voice' to the suffering of those faced with fertility problems (Inhorn, 1994b), and to pay attention to what people themselves deem important rather than to priorities identified by policy makers (e.g. birth and population control). 'Giving voice to' and pointing out people's own concerns requires detailed attention to what people say, and the issues they thereby make relevant (cf. Widdicombe, 1995). Hence, my argument is very similar to Moerman's (1988, p.9) recommendation for ethnographers: 'I am not proposing that ethnographic data be restricted to conversational transcripts and ethnography to their analysis. But I am insisting that those who use talk in order to discover what people think, must try to find out how the organization of talk influences what people say'.

The demonstration of the relevance of details in the design of utterances and their interactional context, leads to a fifth methodological implication which concerns the status allocated to the data. My study highlights problems with treating

talk as pathway to reality, 'out there', or in people's minds. This is a common practice in studies of infertility. To begin with, authors normally allocate research participants' statements about causes, provided in interviews or questionnaires, to mutually exclusive categories of illness beliefs, such as 'STDs', 'witchcraft', 'don't know' (see for instance Dyer et al., 2004; Mariano, 2004; Meera Guntupalli & Chenchelgudem, 2004; Papreen et al., 2000), or, at a more abstract level, 'personalistic causes' or 'naturalistic causes' (Gerrits et al., 1997). However, in order to be able to do this, authors will have to suppress the inevitable variability and ambiguity in responses (Potter & Wetherell, 1987), leading to an artificial categorisation and a reification of people's causal beliefs (Inhorn, 1994). My analysis shows that if one instead pays attention to variability and ambiguity in responses, and examines how this relates to features of the interactional context, it becomes apparent that statements about causes deal with normative and moral concerns. This problematizes the widespread assumption that people's expressions regarding causes reflect the state of their knowledge, or cognitions (Drew, 1991).

In addition, I have shown that reasons for not taking action too, can at least in part be based on the interpersonal functions which they fulfil. For instance, in my data, respondents explain their inaction in such a way that they play down their culpability, by constructing inaction as reasonable or attributing it to external factors, thereby mitigating their responsibility. In studies of infertility in developing countries, not much attention has been paid to people's reasons for not seeking (medical) help (but see Sundby et al., 1998; Unisa, 1999). However, many scholars have examined reasons for not using health services for other reproductive health issues in the developing world[57], such as sexually transmitted diseases (Manhart, Dialmy, Ryan & Mahjour, 2000), and childbearing (Gloyd, Floriano, Seunda, Chadreque, Nyangezi & Platas, 2001; McCray, 2004), in relation to obstetric morbidity and mortality (Lindstrom & Munoz-Franco, 2006; MacLeod & Rhode, 1998; Nabukera et al., 2006). In these studies, reasons for not taking action as indicated by people in questionnaires or interviews are treated as indicators of barriers which should be removed, in order to enable people to make use of health

[57] This is so, presumably because for these problems, unlike for infertility, people are seen as seeking not enough help, or not soon enough.

services available. It will be fruitful to take into account that reasons are put forward within a specific interactional and interpersonal context, and will deal with certain normative and moral issues, rather than seeing them only as straightforward reflections of barriers which need to be tackled. I am not suggesting that reasons which people give for not taking action, such as lack of money or a husband's refusal to go to the hospital, should not be taken seriously and addressed. However, by paying attention *as well* to the interpersonal functions which such reasons fulfil, one can gain new insights into alternative interpersonal issues at stake for people in taking action or not taking action. These could then form a starting point for developing interventions for the promotion of alternative behaviours, which are based on people's own concerns (see section 10.4.3).

Furthermore, assessing the quality of the relationship's of people with a fertility problem on the basis of verbal reports appears also problematic. Considering the apparent relevance of interpersonal, moral issues related to blaming others and being blamed, respondents' constructions of people's relationships can perform various functions. I have mentioned that there is a certain ambiguity in the literature on infertility in developing countries. Overall, the detrimental impact of infertility on people's relationships is emphasized (Gerrits et al., 1998; Inhorn, 2004; Mariano, 2004; Neff, 1994; Riesman, 2005, 2000; Sundby, 1997; Unisa, 1999), but some authors mention that at least some research participants report having good relationships with relatives or community members (Meera Guntupalli, 1998, Dyer et al., 2004), or with their spouse (Dyer et al., 2002; Gerrits et al, 1999; Inhorn, 2003; Pashigian, 2000; Riessman, 2005; Unisa, 1999). It therefore appears that more attention should be paid to the variability in reports regarding the quality of the relationships of people with a fertility problem. In particular, it seems fruitful to examine how variability may be the result of the functions which descriptions of (troubled) relationships fulfil, that is, the interpersonal and moral issues they deal with, which may be triggered by the particular questions asked.

10.4.2 Contributions to theoretical developments in health psychology and health promotion

My analysis highlights problems with common approaches to, and theories of, health related behaviours. Scholars with an interest in health seeking behaviour tend to focus on individual decision makers, whose decisions are dependent on, and caused by, demographic and psychological, cognitive characteristics, in combination with practical inhibitors (cf. MacKian, 2003). This has certainly been the default approach of health psychologists, and those who, working in fields such as health promotion and public health, draw upon health psychology. The causal relationship between individual characteristics and behaviour is explicitly posited and formalised in social cognition models (Connor & Norman, 2005), such as the 'health belief model' (Becker & Rosenstock, 1984), 'theory of planned behaviour' (Ajzen, 1985), or 'self regulation model' (Leventhal, Diefenbach, & Leventhal, 1992). [58] These social cognition models are normally represented as flow-chart diagrams, in which arrows connect cognitions and actions, thus symbolizing the causal relationship between the two (see for an example Appendix C). Psychological attributes which are considered to be predictors of health related behaviour include perceived susceptibility, perceived seriousness (Leventhal et al., 1992) and perceived causes (Leventhal et al., 1980). Causes are seen as determinant of people's health seeking behaviour as well in studies which adopt a less formalized approach and do not draw upon the aforementioned models, (e.g. Meera Guntupalli, 2004; McDonald Evens, 2004) .
I will briefly recapitulate the shortcomings of these common approaches to health seeking behaviour, discussed before in chapter 6. First, they largely neglect the social context in which health related behaviours occur, and the social meanings which these behaviours can obtain (Crossley, 1998; Marks et al., 2005; McKian, 2003; Obermeyer, 1998; Ogden, 1996). I should mention that some social cognition models have attempted to incorporate the social context. For example, the 'Theory of Planned Behaviour' (Ajzen, 1985, 1988) includes the factor 'subjective norm', which is a combination of individuals' perceptions of social norms regarding certain actions, and their motivation to comply with the norm. However, as Ogden (1996)

[58] These models are widely used in studies of various health issues in developing *and* non-developing countries (McKian, 2003; Obermeyer, 2005), but surprisingly, in only two studies of infertility (Benyamini et al., 2004; Lord & Robertson, 2005).

points out, as the social context is only included in the form of a measurement of individuals' beliefs about it, the individualistic nature of this model remains essentially unchanged.

Second, health seeking behaviour is often seen as an outcome of an overly rational calculation of the behaviour's costs and benefits, based on a systematic evaluation of available information (Crossley, 1998; Gillies & Willig, 1997; McKian, 2003; Obermeyer, 2002; Ogden, 1996, Yoder, 1997).

There has been a growing call for more social approaches which pay attention to emotional, interpersonal issues which could be of relevance for people's behaviour, rather than focussing on the individual as a more or less rational, solipsistic decision maker (Crossley, 1998; Gillies & Willig, 1997; Hepworth, 2003; MacKian, 2003; Ogden, 1996; Obermeyer, 2002).[59] This is informed by an increasing recognition that providing information at the individual level is not sufficient to promote health and healthy behaviours (MacKian, 2003) and that avoiding health risks is not necessarily a priority for people (Crossley, 1998; Obermeyer, 2002).

My findings both lend support to, and meet this demand. First, in chapter 5, I highlighted the ambiguity, variability and hesitancy in people's explanations of infertility. Second, I showed how 'illness attributions' are co-constructed in situ, between respondents, interpreters and interviewer, in order to deal with the interactional and interpersonal business at hand. These observations call into question the widespread notion that individuals' illness cognitions are pre-existing mental templates for behaviour, and bring out the problems of rational approaches according to which illness attributions are the result of rational evaluation of information (see chapter 5). Third, in chapter 4, I discussed how people justify engaging in extramarital affairs by constructing a cultural norm which mandates childbearing. This suggests that people's behaviour is informed at least also by social and normative concerns which people bring to bear, and not only by their knowledge about the risks involved in having unprotected sex. Hence, educating people about the health risks of such behaviours appears indeed of limited use. Fourth, the analysis

[59] The growing attention for concepts such as social capital and community empowerment and development in both public health and health promotion can be seen as indicative of an increasing interest in social approaches to health and illness (cf. MacKian, 2003).

presented in chapter 6 also shows that people make taking action into a normative affair, by attending to their inaction as dispreferred breach of normative expectations that they take action, and by playing down their culpability, using various discursive devices and constructions. This highlights the relevance of normative meanings of people's 'health seeking behaviour', which may inform their actions.

Overall then, these findings cast doubt on individualistic and rational approaches to health seeking behaviour, by drawing attention to how people co-construct the meanings of 'illness cognitions', (in)actions, and their reasons, in specific social contexts. The analytic findings discussed are not only of relevance for theoretical notions of health related behaviours, but also have implications for practical attempts to change them. I will address these in the next section.

10.4.3 Practical contributions to health service development and health promotion

Few discourse analysts have attempted to put their work to use (Burr, 1998; Willig, 1999), and applying findings from DA study is not a simple matter (Potter & Wetherell, 1987). Yet, discourse analysis appears particularly suitable to contribute to social and political change. Perhaps counter intuitively[60], this is so in part due to its relativist epistemology. As relativism rejects the notion of objective truth, '[it] offers an ever available lever of resistance': 'nothing ever has to be taken as merely, obviously, objectively, unconstructedly, true' (Edwards et al., 1995, p.39). DA has a liberatory potential because it enables one to challenge and question what is normally taken for granted (Burr, 1995), shows how things could be different, and can create a space for alternative realities (Burr, 1998; Potter, 1998; Willig, 1998).

Moreover, Burr (1998) and Willig (1998) point out that discourse analysts have a responsibility to put their work to use and contribute to social and political change. This in part because in-action too, is a form of action, as disengagement entails supporting the status quo (Willig, 1998). Therefore, scholars inevitably take

[60] Sometimes it is argued that it is due to DA's social constructionist, relativist epistemology, according to which they cannot claim to know the truth, discourse analysts cannot commit themselves to any political position and make recommendations for change. See for powerful arguments against this stance, in addition to the ones I put forward in this section, Burr (1998), Edwards, Ashmore & Potter (1995) and Willig (1998; 1999).

up a certain position in their work and support or subvert particular practices, even if they do this only implicitly. However, leaving it up to the reader's imagination how one's analysis can exactly be put to use, may lead to distortion and abuse (Willig, 1998).

Discourse analytic interventions are not necessarily restricted to facilitating change in ways of talking; they may also contribute to changing ways of acting. As early as 1940, Mills argued that discourse and practices are interrelated, and after him several authors have done the same, arguing that discursive constructions and accounts can constrain or facilitate what can be done (Burr, 1995; Foucault, 1973, 1978; Shotter, 1984, 1993; Stainton-Rogers, 1991; Willig, 1998; 1999). According to Shotter (1984, 1993), this is so because the conversational realities which people construct in talk, have a certain morally coercive structure to them. That is, only certain kinds of next actions, verbal *or* non verbal will be seen as 'fitting', in that they are in line with what others can be assumed to deem appropriate and justifiable (cf. Garfinkel, 1967; cf. Heritage, 1984). To give an example of how discursive constructions and practices may be intertwined, Willig (1999) notes in her study of safe sex practices that participants construct marital relationships as necessarily sexually safe, 'by definition'. This makes marriage incompatible with condom use, and requires partners to take sexual risks in order to negotiate a trusting relationship. Challenging such a construction of marital relationships could therefore facilitate the use of condoms.

Several, interrelated, ways have been identified in which DA can be used for interventions in order to accomplish a certain improvement in people's lives (Taylor, 2001; Willig, 1999). First, discourse analytic work can be used as social critique (Willig, 1999; Taylor, 2001). This involves a critical examination of language use and its consequences, leading to resisting and challenging problematic constructions. Willig (1999) notes that in order to transform social critique into a tool to challenge, authors need to propose *how* resistance and challenge can be achieved, and in which contexts (e.g. courtrooms, campaigns), in addition to academic publications.

Second, DA can be used as a form of empowerment (Taylor, 2001; Willig, 1999), by raising awareness, legitimising what was previously denied or negatively valued, and giving voice to those who were previously unheard (Taylor, 2001). In

addition, Willig (1999) sees empowerment as exploring alternative accounting practices and constructions which are more helpful for people.

In the analytic chapters, I have identified various accounting practices and constructions which seem at least potentially unhelpful. Hence, challenging these constructions, raising awareness of them, and stimulating people to search for alternative constructions whilst increasing their skills to do so, could lead to an improvement in people's lives. First, the construction of a cultural norm, according to which one ought to bear children, appears to contribute to the ordeal of not bearing children, or having only few children. Therefore, the focus could be on the promotion of constructions which acknowledge that bearing children is not a necessity. Second, constructing practices like extramarital affairs and polygamy as logical, necessary and 'automatic' solution to fertility problems may induce people to place themselves at risk of contracting or spreading STDs, including AIDS. In addition, it may contribute to the personal suffering of the wives whose husbands have an affair or take another wife. Thus, it seems desirable to facilitate 'talk' which constructs *not* engaging in extramarital affairs and polygamy as acceptable, as well as to challenge constructions of 'culture' as 'force' which makes people behave in certain 'inevitable' ways. I have shown how this is one strategy which respondents use to justify extramarital affairs and polygamy when faced with fertility problems.[61] There is a risk however, that such a de-construction would result in making people themselves unduly responsible and to blame for having extramarital affairs or polygamous marriages, whereas it may be difficult for them not to engage in these practices. Hence, the emphasis should be put on people's positive potential to make their own decisions, whilst acknowledging the limitations in self-determination as well.

It is worth noting that accounts which reject practices like extramarital affairs when a marriage remains childless may already have a certain 'currency' in Malawi. For instance, in chapter 4, extract 10, the respondent distances himself from the

[61] Before (footnote 51), I have suggested that constructions of practices as cultural can also be used to make people, as cultural members, responsible and to blame for problematic behaviours (Jeffery, Jeffery & Rao, forthcoming), rather than excusing them.This underlines the fundamentally indexical, context bound nature of language use and meaning, and highlights the need to examine how constructions are employed in concrete contexts.

practice that the brother of someone who has a fertility problem sleeps with his wife, by arguing that 'these days, because of this deadly disease, Aids, they are avoiding it now' (lines 127-129). In addition, some respondents rejected engaging in extramarital affairs, divorce or polygamy on the basis of their religion. Making use of such existing health promoting accounting practices will increase the chance of accomplishing change. However, further research is needed in order to examine the prevalence of these practices, and how they are used within specific contexts.

Third, respondents' orientation to seeking action as preferable seems unhelpful, especially in a context in which few medical solutions are available. This strategy may lead to people putting time, effort and money in obtaining what often seems unattainable; a cure for their fertility problem. It may give rise to financial troubles (Inhorn, 1998; Sundby, 2002; Unisa, 1999) and even additional health problems (see chapter 2, Inhorn, 1998; Sundby, 2002).

Note that the construction of taking action as preferable seems unfortunate especially considering practitioners', in particular indigenous healers' claims of (widespread) success, which may give false hope to people in search of a cure. Therefore, it could be beneficial to stimulate people with a fertility problem to frame inaction as deliberately chosen, rather than as prevented by external obstacles. As a result, not taking action, or discontinuing action at an earlier stage may become easier for men and women with a fertility problem.

Fourth, the practice of constructing relationships and any potential troubles, such as extramarital affairs, in such a way that others are not blamed for it, impedes 'standing up' and 'speaking out' against potential trouble. It could therefore be helpful, to critically examine accounts of relationship troubles together with people with a fertility problem, their relatives and community members, and discuss who is made responsible for the trouble, and who else could play a role in troubles. This could be combined with promoting constructions which deem inappropriate differential treatment of people with a fertility problem are given different treatment than other community members, regardless of whose 'fault' this is.

Fifth, I have shown how practitioners manage their competence by attributing problems to external factors, including patients' behaviour and intelligence. This strategy appears problematic, to begin with because it may make patients

unjustifiably responsible, and possibly to blame for problems. In addition, it appears to obstruct critical reflection on whether the particular design and delivery of health services could contribute to problems, and the role which practitioners themselves can play in preventing communication or other problems. Hence, awareness could be raised amongst practitioners about how they construct themselves as not accountable for problems and instead, attribute them to their patients. I have argued that this ties in with practitioners' pursuit of an identity project as competent practitioner (see chapter 8 and 9). Therefore, it seems desirable to search for constructions, together with practitioners *and* their managers, which enable, if appropriate, attributing problems to the design or delivery of services, or to practitioners' own inevitable shortcomings, without threatening practitioners' identities as competent practitioners. It could also be useful to reflect together with aforementioned professionals on issues of professionality, and how this affects practitioners' practices and their interactions with patients.

Several platforms can be identified for the promotion of accounts which are empowering and health promoting, and can contribute to the improvement of service design and delivery. For instance, the media could be used as a resource, in particular, soap-operas and debates on the radio, or plays in villages. Both the radio and plays are popular in Malawi, and already commonly used means for health promotion[62](Matinga &McConville, 2002). In addition, group discussions could be organised in communities about infertility, its consequences and solutions. This would enable identification and discussion of problematic constructions, and alternative, more empowering constructions can be proposed. This could be done as well in marriage rites (personal communication, Rachel Fiedler, July 2003), in which instruction is given to newly married couples about sexual behaviour and about how 'proper' spouses should behave (de Kok, 2005; Matinga & McConville, 2002). It may be possible to design together with the 'instructors' at these rites instructions which include more beneficial, enabling constructions of childbearing and sexual behaviour.

[62] See also the website of the story workshop (http://www.storyworkshop.org), a well-run NGO in Malawi, concerned with community development and health promotion through communication and entertainment.

In order to raise awareness of, and challenge practitioners' accounting practices, meetings can be organised, for instance in hospitals or institutions of medical education, with practitioners themselves, managers and those involved in medical training. In these meetings, extracts from interviews with practitioners could be discussed, with particular attention for the actions which practitioners engage in, and their consequences.

Although in principle desirable, using discourse analysis to contribute to change and development is not without its problems (Willig, 1999; Taylor, 2001). Both Willig (1999) and Taylor (2001) point out that discourse analytic interventions may have unintended, negative consequences. Because research findings are inevitably situated and contingent, 'yesterdays' critique may no longer be relevant, and liberatory discourses can always be subverted' (Taylor, 2001, p. 327). In addition, interventions change contexts, and thus may not longer 'work' in the way it was hoped they would. Willig (1999) argues that therefore, discourse analytic interventions, as any intervention, should always be reflexively monitored for their consequences.

In addition, there is the risk that designing interventions on the basis of discourse analysis leads to the reification of participants' situated construction work and accounting practices (Widdicombe, 1995; Willig, 1999, 1998). Widdicombe (1995) emphasizes the need to retain a focus on how accounts are designed for the local interactional contexts in which they occur. There is no obvious way to solve this problem; it seems that the best one can do is to be aware of the occasioned nature of accounts and design interventions for a specific socio-cultural context, which is the same as the one in which one's research was conducted (Willig, 1999).

Furthermore, using discourse analysis for interventions which promote alternative constructions and accounting practices can be seen as manipulation (Willig, 1999), and thus a problematic exploitation of (white) academics' power. However, Willig (1999) points out that a difference should be made between perpetuating power relations, and the strategic use of 'power' to pass on expertise or skills. In addition, she suggests that discourse analysis can be made into a tool which can be used by collectives to change themselves, rather than a tool to manipulate others. Although Willig (1999) does not spell out how this can be accomplished, it

would seem that this necessitates an intense involvement of members of the communities, or those for whom one intends to do good, in the design of interventions[63].

Moreover, Willig (1999) warns that one should acknowledge that talk is grounded in social, material, and institutional structures, as otherwise one would falsely suggest that individuals can 'shake off' unhelpful constructions. This could lead not only to unrealistic optimism, but also to a form of victim blaming, making people responsible for whether they get rid of unhelpful constructions or not. Therefore, as Willig (1999) points out, discourse analytic interventions are no substitute for other, more 'direct', political interventions.

It will be clear then, that applying discourse analysis is not a straightforward or simple matter, and the suggestions provided in this chapter need to be further researched and developed before they can be implemented. However, the problems and challenges involved in applying discourse analysis do not mean that one cannot, or should not, attempt to put discourse analytic work to use. I agree with Willig (1999, p.158) that the risks of withholding recommendations for change are greater than its benefits: 'we need to mobilize our skills as discourse analysts in order to intervene in the struggle over how language constitutes our world(s)'.

10.5 Conclusion

This study is the first qualitative study of infertility in Malawi, and the first study of infertility which uses discourse analysis, informed by conversation analysis. In this thesis, I have shown that 'norms' regarding childbearing are resources available for use, rather than causal, explanatory factors; that 'illness attributions' and 'health seeking behaviour' are intertwined with normative and moral concerns rather than neutral, cognitive matters; and that also indigenous and biomedical practitioners' explanations and descriptions of practices are of a fundamentally interpersonal nature, in that they are employed to manage accountability, in relation to their professional expert identity.

[63] This suggestion is in line with community development, an increasingly popular approach in health promotion (Naidoo & Wills, 2005; WHO, 1997)

My study then, demonstrates that people are far from 'cultural dopes' (Garfinkel, 1967). In their descriptions of their knowledge and actions, people with a fertility problem, significant others, and practitioners, actively and skilfully employ normative notions to manage the interactional and interpersonal business at hand, which is often imbued with (potential) moral judgements. Thus, my research lends support to Crossley's (1998, p.39) claim that people's actions 'have their own alternative logic and validity that is related in a complex fashion to the cultural and moral environment in which they live', and do not 'conform to rational, logical, value-free ways of thinking'

In future work, it will first of all be valuable to explore in more detail how interventions can be developed on the basis of this study's findings. Second, it would be interesting and useful to record and analyse interactions in consultations between different kinds of practitioners (e.g. indigenous healers, Malawian and expatriate practitioners) and infertility patients, in particular to see how (communication) problems which may arise are managed in situ. Third, it will be valuable to focus on other (reproductive) health problems to which moral and normative issues seem pertinent. Examples of these, of particular relevance to sub Sahara Africa, are abortions, miscarriages, and maternal mortality, as these bring issues of blame and responsibility, for couples, community members and practitioners, into sharp relief.

To conclude, although seemingly benign, infertility in sub Saharan Africa is a serious problem, which has too often, and for too long, been ignored. In Malawi, as well as in other countries in sub-Saharan Africa, there is a great need for the design of culturally sensitive, reproductive health promotion programs and services, which focus on people's *own* concerns related to childbearing. My thesis can form a valuable contribution to the design of such services and programs. It gives voice to people in Malawi who suffer from fertility problems, their significant others, and those who provide care for them, by examining in detail what people say, the understandings they thereby draw upon, and the interpersonal issues they deal with, in their own terms.

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Appendix A: Methodological features of the studies reviewed

Table 2. Epidemiological and demographic studies of infertility

Study	Location	Sample	Data collected	Analysis
Gabon Collett et al (1988) Infertility	Hospital in semi-urban centre in Gabon	Women, suffering from primary and secondary infertility (N=350), constituting the total of clients of infertility clinic during 2 years	• Medical history • Medical investigations • Demographic data	Descriptive statistics (percentages) and inferential statistics (t-tests)
Gambia Walraven *et al* (2001) *Reproductive health*	20 villages in the Gambia	1) Female community members (N=1348) Between 15-54 year *Sampling: Random (cluster sampling)*	• Survey (demographic data, reproductive illness, health seeking behaviour) • Physical examinations (assessment of sexual & reproductive illness)	Descriptive statistics: frequencies of e.g. reproductive illness (STDs, infertility)
Malawi Barden-O'Fallon (2005) *Infertility*	Villages in Mangochi distict	1) Community members, female (N=678: age 15-34) & male (N=362: age 20-44) *Sampling: random (multi stage probability sampling)*	• Longitudinal (2 years) survey (re. child wish, sexual behaviour, knowledge of STDs/ HIV, infertility treatment-seeking) • Physical examinations (STDs)	Descriptive statistics (percentages and inferential logistic regression (odds ratios)
Tanzania Favot et al. (1997) *Infertility*	Hospital in town in north-west Tanzania	1) Women (N=154) presenting in infertility clinic and not having given birth during 5 year whilst exposed to conception *Sampling: Purposive* 2) Women (N=259) who came to hospital for delivery (control group) *Sampling: Purposive*	• Structured interviews (demographic data, obstetric illness and STD history, behavioural risk factors for HIV), • Physical examinations re. prevalence of STDs • Semi-structured re-interviews with selection of women (N=20).	1.Structured interviews and physical exams: Inferential statistics (odds ratios/logistic regression) 2.Semi-structured Interviews: content analysis.

Table 2 cont'd

International studies				
Study	**Location**	**Sample**	**Data collected**	**Analysis**
Cates et al. (1985) *Infertility*	Infertility clinics in 25 developing and developed countries	8500 couples suffering from primary and secondary infertility, during a period of at least 1 year *Sampling: Purposive*	• Medical examinations, • self reported history of disease	Descriptive statistics: distribution of demographic features and diagnoses
Ericksen & Brunette (1996) *Infertility*	Comparison survey data of 27 African nations	1) Women without life born child (primary infertility) or with at least one life born child (secondary infertility) who have been exposed to conception for between 5 and 7 years *Sampling: Random*	• Demographic and Health Surveys & World Fertility Surveys	Logistic regression, odds rations re. (demographic) predictors of infertility
Larsen (1995) *Infertility*	Comparison of survey data from Cameroon and Nigeria	Married women between 20-44, not having given birth for at least 5 years. *Sampling: Random*	• Demographic and Health surveys & World fertility Surveys of Cameroon and Nigeria	Inferential statistics (logistic regression to determine which (demographic) variables predict infertility (e.g. occupation, ethnic group). student t-test to determine differences in infertility patterns between Cameroon and Nigeria.)
Larsen (2000)	Comparison of survey data from 28 African nations	Married women between 20-44, not having given birth for at least 5 years. *Sampling: Random*	• Demographic and Health Surveys & World Fertility Surveys	Descriptive statistics: percentages re. primary and secondary rates

Appendix A

Table 3. Studies of psychological correlates of infertility

Study	Location	Sample	Data collected	Analysis
Health seeking behaviour				
van Balen , Verdurmen & Ketting (1997)	Holland	• Infertile and previously infertile couples (N=131), identified through national survey *Sampling: random*	• Survey re. solutions sought and motivations	Descriptive statistics (percentages)
Greil & McQuillan (2004)	USA	• infertile women and previously infertile couples (N-196) identified through survey	• Survey re. solutions sought and variables such as intent to get pregnant, locus of control	Descriptive statistics (percentages)
Rhajkowa (2006)	U.K/Scotland	• couples (N=732), clients and former clients of infertility clinic *Sampling: Purposive* (all clients in 6 year period)	• Questionnaire: (Demographic data, treatment information, reasons for discontinuation of treatment)	Descriptive & inferential (correlations)
Psychological distress				
Aghanwa, Dare & Ogunniyi (1999)	Ile-Ife, Nigeria	• infertile clients of infertility clinic (N=37), below 45 years old • 'apparently healthy women', selected from hospital workers, matched by age and marital status (N=37) *Sampling: Purposive*	• Structured interviews • Psychometric assessment (General Health Questionnaire-30) • Clinical assessment	Inferential statistics: X^2, t-test.
Anderheim et al. (2005)	Germany	• female clients of IVF clinic (N=166) *Sampling: Purposive*	• Questionnaire: Demographic information One month before start IVF treatment , and 1 hr before ocyte retrieval: • Various psychometric assessments: General psychological well-being; Effects of infertility on well-being; optimism versus pessimism, intensity childwish • Treatment outcome	Descriptive and inferential statistics (univariate analysis, logistic regression)

Table 3. cont'd

Study	Location	Sample	Data collected	Analysis
Anderheim et al. (2005)	Germany	• female clients of IVF clinic (N=166) *Sampling: Purposive*	• Questionnaire: Demographic information One month before start IVF treatment , and 1 hr before ocyte retrieval: • Various psychometric assessments: General psychological well-being; Effects of infertility on well-being; optimism versus pessimism, intensity childwish • Treatment outcome	Descriptive and inferential statistics (univariate analysis, logistic regression)
Dhillon et al. (2000)	Canada	• male clients (N=90) in infertility clinic *Sampling: Purposive*	• Questionnaire: Demographic information • Psychometric assessments (depression, anxiety, dyadic adjustment, self esteem, coping)	Descriptive (means and SDs)
Dyer et al. (2005)	Cape Town, South Africa	• women (N=120) presenting for first time at infertility clinic. Women belonged to black, white and coloured ethnicities • women (N=120) presenting to local family planning clinic (control group) *Sampling: Purposive*	• Questionnaire: Demographic information • Psychometric assessment: Psycho-social distress (adapted version of Symptom Checklist-90-R);	Descriptive and inferential statistics (tests of significance)
Fassino et al. (2002)	Turin, Italy	• Infertile couples (N=119), presenting for the first time at infertility clinic hospital, all white, age 18-45. • 80 fertile couples, recruited through nurseries, all white, age 18-45 (control group) *Sampling: Purposive*	• Temperament and Character Inventory (TCI) • Interviews by psychiatrist • Clinical/medical examinations	Inferential statistics: ANOVA/ Stepwise regression

Table 3. cont'd

Study	Location	Sample	Data collected	Analysis
Lancastle & Boivin (2005)	U.K	• Women (N=97) presenting at infertility clinic, about to undergo IVF treatment *Sampling: Purposive*	• Psychometric assessment (three months before start of treatment): Coping, Trait anxiety, Dispositional optimism, Biological responses to IVF	Inferential statistics: Structural equation modelling
Merari et al. (2002)	Israel, Tel Aviv	• Couples (N=113), presenting at infertility clinic, about to undergo IVF treatment *Sampling: Purposive*	• Questionnaire (demographic information, emotional reaction, interspouse relations) • Psychometric assessments: state & trait anxiety, depression	Descriptive and inferential statistics (regression)
Pasch et al. (2002)	California, USA	• Infertile couples (N=48) presenting at infertility clinic *Sampling: Purposive*	• Interviews • Questionnaires • Marital discussion task	Descriptive and inferential statistics (t-tests, multiple regression analyses).
Pook, Krauze & Rohrle (2000)	Germany	• Male clients (N=55) of infertility clinic, with no organic cause of infertility *Sampling: Purposive*	• Psychometric assessments: Coping style;infertility distress • Days of sexual abstinence • Clinical/medical examination (sperm concentration)	Inferential statistics: correlations & analysis of variance
Souter et al. (2002)	U.K/ Scotland	• female clients of infertility clinics (N=505) *Sampling: Purposive*	• Demographic data , e.g. age, cause of infertility, primary/secondary infertility, number of clinic attendances • Psychometric assessments: anxiety, depression (GHQ-28), physical and social functioning (SF-36) and others	Descriptive statistics (percentages) and inferential statistics (tests of significance)
Sysdjo et al. (2005)	Linkoping, Sweden	• 45 infertile couples, presenting at infertility clinic, experienced failed IVF treatment. *Sampling: Purposive*	• Longitudinal: ENRICH inventory (assesses partners' evaluation of relationship), administered at first treatment, 6 months after and 1.5 years later.	Descriptive (means and SDs) and inferential statistics (correlations)

Appendix A

Table 3. Cont'd

Psychological distress & Gender				
Study	**Location**	**Sample**	**Data collected**	**Analysis**
Edelmann & Connolly, 2000	U.K	• Group 1: infertile couples (N=116) presenting at infertility clinic • Group 2: infertile couples (N=130) presenting at IVF clinic *Sampling: Purposive*	• Longitudinal:Psychometric assessments: e.g. State-Trait Anxiety Inventory, General Health Questionnaire, Beck Depression Inventory. Assessments administered at first consultation and 7 months (group 1) / 6 weeks (group 2) later and after completion 1st treatment cycle	Descriptive and inferential statistics
Psychological distress, Coping & Cognitions Abbey et al.(1991)	USA	• Infertile couples (N=185), suffering from primary infertility, recruited mainly form infertility clinics, also from self-help groups and through newspapers. *Sampling: Purposive*	• Structured interviews with husbands and wives separately: assessments of various psychological factors, e.g. life quality, self esteem, perceived control, 'fertility problem stress'	Descriptive and inferential statistics
van den Akker (2005)	U.K	176 women, former clients of ART clinics (n=43), adoption agencies (n=105) and surrogacy agencies (n=28) *Sampling: Purposive*	• Demographic data • Reproductive health problems • Psychometric assessment: e.g. Quality of Life, coping style (COPE), anxiety, depression, (GHQ-28)	Descriptive and inferential statistics (tests of significance, logistic regression)
Benyamini (2004)	Israel, Tel Aviv	• women (N=310), clients of infertility clinic *Sampling: Purposive*	• Psychometric assessment: Illness cognitions (Illness Perception Questionnaire), coping style (Coping with Infertility Questionnaire), emotional distress and wellbeing (Infertility Specific Well-being and Distress Scales)	Inferential statistics (Structural Equation Modelling)

Table 3. Cont'd

Study	Location	Sample	Data collected	Analysis
Litt et al. (1992)	USA	• Female clients (N=41) of IVF clinic, suffering from secondary and (predominantly) primary infertility, who completed IVF cycle. *Sampling: Purposive*	• Demographic data • Questionnaire about perceived effects of infertility on various domains of life • Structured interviews about e.g. perceived causes, probability of success • Various psychometric assessments, pre and post IVF treatment (e.g. locus of control, coping style, physical and emotional state (BSI)	Descriptive and inferential (tests of significance, stepwise logistic regression) statistics
Lord & Robertson (2005)	3 ART units in U.K	• 20 men and 30 women presenting at infertility clinic (18 couple sand 14 individuals), mainly white *Sampling: Purposive/Accidental*	Demographic Questionnaire, Illness perception Questionnaire-Revised, Hospital Anxiety and Depression Scale (HADS), COPE (Brief Version)	Descriptive and inferential statistics (correlations and regression)
Schmidt et al. (2005)	Denmark, Copenhagen	• Infertile men and women presenting at infertility clinics, who had not achieved pregnancy after 12 months of infertility treatment. N=2250 at T1 (start treatment), N=1934 at T2 (after 12 months of treatment) *Sampling : Purposive*	*Longitudinal:* Questionnaire, partly based on the Fertility Problem Stress Inventory, administered at T1 (start treatment) and T2 (after 12 months of treatment)	Descriptive and inferential statistics (χ^2)
Vieyra et al. (1990)	USA	• men (N=33), 31 women (N=31), not married to each other.39 recruited from infertility clinic, 10 through newspaper, 13 from local meeting of RESOLVE, infertility support group	• Structured interviews about (causal) beliefs and reactions • Psychometric assessment (anxiety , depression, hostility (Symptom checklist-90)	Interviews: Content analysis Descriptive and inferential statistics (correlations)

Appendix A

Table 4a. Ethnographic studies of infertility in sub Saharan Africa.

Study	Location	Sample	Data collected	Analysis
Botswana Upton (2001) *Infertility*	Maun, administrative capital/large village of district of Batawana ethnic group.	1) Community members[64] (N = unknown) *Sampling: Unknown*	1)Informal interviews 2) semi-structured interviews 3) participant observations	Thematic [65]analysis
Cameroon Feldman-Savelsberg (1994) *Infertility*	Bangangte, kingdom in Cameroon, royal compound villages, hospitals	1) Community members (42) 2) Biomedical practitioners (53) 3) Traditional healers (7) 4) Schoolchildren (238) *Sampling: unknown*	• Semi-structured interviews (1, 3) • Questionnaires (2) • Essays (re. e.g. family planning, sterility) by school children (4) • Archival research in governmental, trade and mission archives. • Participant observations in royal compound villages, hospitals	Thematic analysis, focus on metaphors used.
Chad Leonard (2000) *Infertility*	City of Sarh	1) Women over 15 years old (N=170) *Sampling: Random (cluster sampling)* 2) Women who defined themselves as having fertility problems (N=21), including women suffering from primary and secondary infertility. *Sampling: Purposive*	• Semi-structured interviews (1) • 'Less structured' supplementary conversations (2)	Thematic

[64] The category 'community members' includes both people with and without fertility problems

[65] Many qualitative studies do not state explicitly what type of analysis used, nor describe how data were analysed. I use the label 'thematic analysis' for those studies, in which data is categorised according to certain themes (e.g. 'consequences', 'solutions sought'), which do not appear to have used a pre-structured coding scheme, and which do not provide a label for the type of analysis they used.

Table 4a. Cont'd

Study	Location	Sample	Data	Analysis
Gambia Sundby (1997) *Infertility*	Town 'Bakau', and 2 villages	1) Women (N=243) *Sampling: Random* *99% currently married, 35% had been married before, 16% more than once* 2) Infertile women (N= 21), infertile men (N=2) 3) Health care workers (N=7) 4) Local leaders (N= unknown) 5) Traditional healers (N=unknown) *Sampling 2-5: Purposive*	• Survey (1) • Semi-structured interviews (2) • Unstructured interviews (3) • *Interviews were conducted in villages/homes*	Thematic
Sundby, Mboge & Sonko (1998) *Infertility*	24 areas in the Gambia	1) Head of households (N=500) *Sampling: Random* 2) Women suffering from primary and secondary infertility, based on criterion of 3 years of exposure to conception without giving birth (N>25) 3) Village leaders: traditional leaders, traditional birth attendants, village health workers, 'influential women' (N= unknown) 4) Biomedical practitioners (14) + five clinics/health centres (N=?) *Sampling: snowballing*	• Survey/structured questionnaire: (re. number and age of women of fertile age per household, number of children) (1) • Questionnaire for infertile women (re. fertility & marital status, use of family planning, traditional and biomedical care (2) • 25 semi-structured interviews (2), held in communities • Semi-structured interviews (3) • Semi-structured interviews (4) • Medical statistics	• Survey: descriptive (percentages) • Interviews (thematic/
Mozam-bique Agadjanian (2001) *Reproductive health*	Maputo (city)	1)Women (N>84) 2) Men (N>60) All of 'reproductive age' and married *Sampling: Unknown*	• Semi-structured interviews (1,2: 84 women and 60 men) • 16 Focus groups (1,2)	Thematic
Gerrits (1997) *Infertility*	Village & suburban area	1) Infertile women (N=34):Want to get pregnant but fails to do so, irrespective of duration. 2) Cured women (N=6):Resolved their fertility problem in someway 3) Fertile women (N=10): Never experienced any infertility problems *All belonging to ethnic group 'Macua'.* 4) Traditional healers ('several') 5) Biomedical personnel: medical doctor (N=1), nurse (N=1) 6) Community members (including elderly men). *Sampling: mainly snowballing/*	• Semi-structured interviews(1-6) • Participants observation	Thematic

Table 4a. Cont'd

Study	Location	Sample	Data	Analysis
Mariano (2004) *Infertility*	Rural communities in Magude district	1) Infertile women (18) suffering from primary (never conceived) and secondary infertility (6), i.e having at least one live child. 2) traditional healers 3) biomedical practitioners *Sampling: Snowballing/networking*	• Semi-structured interviews (1), *held in women's homes* • Informal interviews with (2,3)	Thematic / 'case centred research', i.e. 3 cases discussed in more detaill
Nigeria Pearce (1999) *Infertility*	Yoruba district, south west Nigeria	**1)** Male and female community members (N=104) 2) Members of Charismatic church in Yoruba land (N=unknown) All respondents belonging to ethnic group Yoruba *Sampling: Unknown/purposive*	• Structured interviews (1) • Semi-structured interviews (2) • Focus groups (2) • Ptc observation (2) • Documents	Thematic
South Africa Dyer et al (2005)	Cape Town, infertility clinic at hospital	1) Men (N=27), suffering from both primary and secondary infertility -of various ethnicity, mostly married (N=24) *Sampling: Purposive*	• Semi-structured interviews	Grounded theory/thematic[1]
Dyer et al (2002a) *Infertility*	Cape Town, infertility clinic at hospital	1) Women (N=30), suffering both primary and secondary infertility of various ethnicity, mostly married (N=26) *Sampling: purposive*	• Semi-structured interviews	Grounded theory/thematic
Harrison & Montgomery (2001) *Reproductive health*	Two rural areas in Kwazulu-Nataal	1) Key informants (N=() *Sampling: Purposive* 2) Female community members (N=114), age between 16-49, both married and single (56%) *Sampling: Random*	• Semi-structured interviews (1), focussing on life narratives, i.e. major events in women's lives, details of childbearing/ illness • Survey about demographic data, reproductive health knowledge, use of health services.(2)	Survey: descriptive statistics (percentages), interviews: 'textual and narrative analysis'

Appendix A

Table 4b Ethnographic studies of infertility outside sub Saharan Africa

Study	Location	Sample	Data	Analysis
Bangla desh: Papreen et al (2000) *Infertility*	Slums of city of Dhaka	2) Fertile men (60) and women (60), of reproductive age, poor, married *Sampling: Random* 3) Infertile women (20), defined as not having conceived after trying for at least 2 years 3) Key informants: traditional healers (2) and religious leader (1) *Sampling: purposive*	• Semi-structured interviews • Interviews conducted in people's homes	Thematic / case-centred research
Egypt: Inhorn (1994) *Infertility*	Alexandria	1) Infertile women (N= 190), 100 presented at teaching hospital	• Semi-structured interviews • Participant observations	Thematic
Egypt: Inhorn (2003) *Infertility*	Private infertility clinic in hospital in city of Alexandria	1) Infertile women (N= 190) 2) Infertile couples (N= 66) *Sampling: Purposive , most recruited in infertility clinic, others unknown*	• Semi-structured interviews • Participant observations	Thematic
India: Meera Guntup alli & Chechel gudem (2004) *Infertility*	3 Villages in state Andhra Pradesh	1) Women (N=5) suffering from primary or secondary Infertility: wanting to get pregnant but not succeeding, irrespective of time. 2) Cured women(N=22) 3) Fertile women (N=11) 4) Key informants: elderly women (N=5), midwife (N=1), Shamans/spiritual healer (N=2), herbalists (N=2), tribal village heads (N=2). -all participants belong to ethnic group Chenchu *Sampling: Purposive & snowballing*	• Semi-structured interviews *Conducted in villages*	Thematic

Table 3b. Cont'd

Study	Location	Sample	Data	Analysis
Neff (1994) *Infertility*	Kerala	Ethnic group 'Nayars' in South India *Sampling: unknown*	• Participant observations • Informal conversations	Thematic
Riess-man (2000) *Infertility*	Kerala	1) Childless women (N=32), *Sampling: purposive/theoretical*	• Semi-structured interviews. Conducted in women's homes/private room in clinic	Grounded theory /thematic
Riess-man (2002) *Infertility*	Kerala	1)Childless women (3), selected from larger corpus (N=32) *Sampling:purposive/theoretical*	• Semi-structured interviews. Conducted in women's homes/private room in clinic	Narrative analysis
Unisa (1999)	Andhra Pradesh	1) Childless women (N=332) *Sampling: All childless women identified from random sample* 2)Key-informants: Doctors, midwives	• Structured interviews/Questionnaire • Clinical examination • Case studies (n=60): Semi-tructured interviews	Thematic
Vietnam: Pashigian (2002) *Infertility*	City of Hanoi, north Vietnam, and surrounding villages	1) Women who were seeking infertility treatment or had sought treatment in the past (N=39), suffering from primary (N=20) or secondary infertility (N=19) 2) Husbands of women seeking infertility treatment (N=?) 3) Women with at least 1 child, who had not experienced infertility (N=10) *Sampling: Unknown*	• Questionnaires • Interviews • Reproductive and life histories Data collected in infertility clinic in hospital, maternity clinic, women's homes, locations in the city	Thematic

Table 5. Studies of medical practice in relation to infertility

Study	Location	Sample	Data	Analysis
Malin (2003)	Finland	Physicians providing IVF and other infertility treatment (N=14) *Sampling: Purposive?*	• Semi-structured interviews	Thematic
Pfeffer (1993)		*Sampling: Purposive?*	• Medical literature	Thematic
Sandelowski (1990)	USA	*Sampling: Purposive?*	• American medical literature on infertility from 19th century onwards	Thematic
Steinberg (1997)	U.K	IVF practitioners working in IVF clinics in U.K (N=24) *Sampling: Purposive*	• Survey, open and closed questions	Thematic

Appendix B: Numbers of respondents, per category

Table 6a. Respondents pilot and main study

Respondents pilot study					
		Recorded		Not recorded	
		Without interpreter	*With interpreter*	*Without interpreter*	*With interpreter*
Biomedical practitioners (Total recordings: N=5)	Malawian clinical officer, medical assistant.	4	-	1	-
	Nurse	1	-	-	-
	HSA	-	-	-	-
	Expatriate doctor	-	-	4	-
Indigenous practitioners (Total recordings: N=2)	Indigenous healer	-	1	-	-
	Traditional birth attendant	-	1	-	-

Table 6b. Respondents main study

Respondents main study					
		Recorded		Not recorded	
		Without Interpreter	*With Interpreter*	*Without Interpreter*	*With interpreter*
Biomedical practitioners (Total recordings: N= 27)	Malawian clinical officer, medical assistant	13	-	1	-
	Malawian nurse	5	-	2	-
	Malawian HSA	5	-	-	-
	Expatriate doctor	4	-	1	-
Indigenous practitioners (Total recordings N=6)	Indigenous healer	-	5		-
	Traditional birth attendant	-	1	-	-
Significant others (Total recordings: N=7)		5	2	-	-
People with fertility problem (Total recordings: N=21)	Man	4	4		
	Woman	8	5	1	

Appendix B

Table 6c. Total number of respondents in recorded interviews

Total number of recorded respondents in pilot + main study		
	Without interpreter	**With interpreter**
Malawian Biomedical practitioners	28	-
Expatriate Biomedical practitioners	4	-
Indigenous practitioners	-	8
Significant others	5	2
People with fertility problem	12	9
Total respondents	68	

Appendix C: Interview-schedules

I. Men and women with a fertility problem

1. Experience of being infertile

1. (if unknown) Do you have any children?
2. Would you like to have some (more)?
    a. Why?
3. For how long have you been trying?
4. With whom do you live?
5. (if spouse not mentioned) Does your husband/wife live there too?
6. Would he like to have more children?
    a. Why?
7. Has anything changed in the relation with your husband/wife because you can't have (another) child(ren)?
    a. In what way, can you give examples?
8. Has it affected anything in your relationship with others, such as friends, relatives, people here in the village /neighbourhood?
9. With whom has your relationship changed?
    a. In what way?
10. Do you think that people would treat you differently if you'd get pregnant (once more)?
    a. In what way?

2.Explanations of infertility

11. Why do you think that people here become infertile sometimes?
12. (give examples if no response forthcoming, e.g STDs, abortion)
    a. And does witchcraft make them infertile ?
    b. And what about spirit possession?
    c. Is there anything else what you think may cause infertility?
13. What do you think is the cause of *your* infertility?
    a. Why do you think that is the cause?
    b. Solutions sought
14. Did you do anything in order to try to have a baby?
    a. What did you do?
15. Did your husband do anything?
    a. What did he do?
16. Did you speak to others about your child-wish?
    a. Whom did you speak to?
17. Can you tell be something about what you discussed with them?
18. Did you seek other people's help?
    a. From whom did you seek help?
    b. (if doctor) Was it a particular kind of doctor?
    c. Why did you go to that specific doctor?
    d. Did you go to other doctors as well?
    e. Why?

3.Expectations western/indigenous doctor

19. Before you visited him/her, did you expect that the doctor would be able to help you?
20. What did you expect the western doctor would do at the consultation?
21. Did you expect him/her to examine you?
    a. (if yes) What kind of examinations did you expect?
22. Did you expect him to examine your husband?
23. Did you expect him to give you advice?
    a. What kind of advice did you expect?
24. Did you expect him to give you some kind of treatment?
    a. What kind of treatment did you expect him to give you?

4.Experience western/indigenous doctor

25. (if consulted doctor) What happened at the consultation?
26. Did he examine you?
    a. (if yes) What kind of examination?
27. Did he give advice?
    a. What kind of advice?
28. Did he give you some kind of treatment?
    a. What kind of?
29. Could the western doctor help you with your problem?
30. Did you feel comfortable when you were talking to the doctor?
    a. (if not) Why not?
31. Did you understand what the doctor was doing?
    a. If anything, what did you not understand?
32. Did you understand what he/she was telling you?
    a. If anything, what did you not understand?
33. Do you think that the doctor understood you?
    a. Did he for example understand what exactly your problem is?
    b. Why do you think that?

34. Did you perhaps do anything else to try to get pregnant?

II. Indigenous and biomedical practitioners

1. Experience with infertility-patients

1. Could you tell me about the kind of work you do, in this hospital/centre/clinic?
2. Do you sometimes see people with a fertility problem at your consultations?
    a. How often do you see patients with a fertility problem?
    b. Are those mostly men, women, or do couples come together?
3. Could you tell me about these consultations, what happens at them?
4. What do the patients usually tell you about why they come and see you?
5. What do you tell them at the consultation?
6. Are there any non medical problems you are faced with when trying to help infertility-patients?
7. Did you ever experience misunderstandings or other communication problems between you and your patients?
    a. Can you give me an example?
8. Have you had any special training for dealing with infertility patients?
    a. (if yes) what kind of?
    b. Where?

2. Explanations of infertility

8. What are the main causes of infertility of the patients you see?(if not mentioned yet)
    a. And does witchcraft make them infertile ?
    b. And what about spirit possession?
    c. Could God or Allah make people infertile?
    d. Any other causes not mentioned yet?
9. What do your patients think is the cause of their infertility?
10. Did your ever experience that your patients have a different opinion about the cause of their infertility than you?
    a. (if yes) How did you notice?
    b. What did you tell them?

3. Solutions offered

11. How do you in general try to help infertile patients?
12. Do patients usually accept your advice?
    a. (if not) Can you give me an example of a case in which a patient did not accept your advice?
13. Do you have any idea why patients sometimes do not accept your advice?
14. How do your patients usually feel about what you offer them?

a. Are they satisfied with what you offer them?
b. Can you tell me about a time that that was the case?
c. Are they also disappointed sometimes?
d. Can you tell me about a time that that was the case?

4. Ideas about patients' expectations

15. What do you think your patients expect from the consultation with you?
    a. For instance, in terms of treatment, examinations
    b. Do they expect you can cure them?

5. Relationship with other healers

16. Do your patients also seek other solutions than consulting you?
    a. What kind of?
17. What do you think about that?
18. Do you know what indigenous healers/western doctors do for people with an infertility problem?
19. Do you ever meet indigenous healers/western doctors yourself?
    a. When for example do or did you meet a traditional healer/western doctor ?
20. Do you ever meet up with indigenous healers to discuss medical problems you encounter during your work?
21. Do you ever refer your patients to traditional healers?

6. Perceptions of fertility/infertility

22. Is it important to be fertile here?
    a. Why?
23. What are the consequences of being infertile for the people you see?
    a. Are these the same for men and women?
    b.(if different) In what way are they different?

III. Significant others

1. Experience with someone who is infertile

1. Do you know someone who has a problem with having children?
2. Is he/she married?
3. What is your relationship with him/her/them?
4. How do you know that she/he/they[66] have this problem?
5. Did they tell you themselves?
    a. What did they tell you?

2. Attribution of importance to (in)fertility

6. Do you think it is important for your …(e.g friend/relative/neighbour) to have (more) children?
    a. (if yes) Why do you think is having (more) children important for them?
    b. Is this important in the same way for your ….as for his/her partner?
    (if not) Why not?
7. Did he/she/they themselves tell you it is important for them to have (another) baby?
    a. What did he/she/they tell you?
8. Do you think he/she/they are unhappy with the number of children they have/with the fact that they do not have a child?
    a. Why do you think that?

3. Explanations of infertility

9. What do you think is the cause of your friends'/neighbour's/…. problem?
10. Why do you think that?

11. What do you think are in general the main causes of infertility in Malawi?
    a. Do you think STDs can be a cause?
    b. And abortion?
    c. And does witchcraft make people infertile?
    d. And what about spirit possession?
    e. Is there anything else what you think may cause infertility?

4. Perceived Solutions

12. Do you have any idea about whether your friend/neighbour/…. has tried to do anything about their problem?
    a. (If yes) Do you know what kind of solutions he/she/they have sought?
13. Do you think these were the right solutions?
    a. Why/why not?
14. What would you recommend them to do?
    a. Do you think that they should go to some kind of doctor?
    b. What kind of doctor do you think they should go to?
    c. Why that type of doctor?
    d. (if not mentioned) Should they go to a traditional healer?
    e. Why?
    f. (if not mentioned) Should they go to a western doctor?
    g. Why?

5. Role of relationships

15. Is there any way in which you could help your…….
    a. In what way?
    b. Did you give him/her/them advice?
    c. Could you give them any kind of emotional support to cope with their problem?
16. Would your relationship with him/her/them be different if they would have children?
    a. In what way?
    b. (if unclear) Would you for example do other things together with him/her/them if they would have children?

6. Community's perceptions of people with a fertility problem

17. Do you think that people here in the village/neighbourhood/community know about his/her/their problem?
    a. Many?
    b. Why do you think that, how do you know?
    c. Do you think his/her/their family knows?
    d. Which members of the family?
18. How do you think do other people know about your friends'/neighbours'/… problem?
19. How do you think that people, here in the village/neighbourhood/community think about him/her/them?
    a. How do they treat him/her/them?
    b. Do they treat them differently then those couples who have (plenty of) children?
    c. (if yes) What is your opinion about that?
    d. Is there a difference between how people treat your friend/neighbour/.. and his/her partner?
    e. (if yes) What is your opinion about that?
20. What do people in the community here think is the cause of his/her/their failing to have (another) baby?
    a. Why do you think that people think that?

Appendix D: Transcription notation[67]

(.)	Shortest hearable pause
(3)	Exactly timed pause[68]
Cu-	A dash denotes a sharp cut-off of a prior word or sound
Lo:ng	Colons show that the speaker has stretched the preceding letter or sound
(word)	Material within brackets represents the transcriber's guess at an unclear utterance
( )	Unclear speech or noise to which no approximation is made
run=	'Equals' signs link material that runs on
=on	
?	Indicates a rising tone
.	Indicates a 'natural' ending
,	Indicates a 'continuing' intonation
!	Exclamation marks are used to indicate an animated or emphatic tone
under	Underlining indicates emphasis
CAPITALS	Capitals indicate speech noticeably louder than that surrounding it.
° soft °	Degree signs indicate speech spoken noticeably more quietly than the surrounding talk.
Over[lap	Square brackets between adjacent lines of concurrent speech denote
[Overlap	the start of overlapping talk
> <	'More than' and 'less than' signs indicate that the talk they encompass was noticeably faster than the surrounding talk
↑	Hightened intonation
((brother))	Material in square brackets indicates transcriber's commentary.
[his]	When context suggests that respondent uses the 'wrong' gender, this is put in square brackets. Note that indigenous languages in Malawi do not have a specific words to indicate gender.

Abbreviations

I used the following abbreviations to indicate 'categories' of respondents:

Inf.w = Woman with fertility problem
Inf.m = Man with fertility problem
s.o. = Significant other
gyn. = Gynaecologist
m.d =medical doctor
c.o. = Clinical officer
m.a. = Medical assistant
HSA = Health surveillance assistant
Ind.h = Indigenous healer
TBA =Traditional birth attendant
((expat.))= expatriate practitioner

All text in ***italics*** is a translation.

[67] Modified version of those developed by Gail Jefferson (1984)
[68] Informal beat count was used, as recommended by ten Have (1999)

Appendix E. Leventhal's self-regulatory model

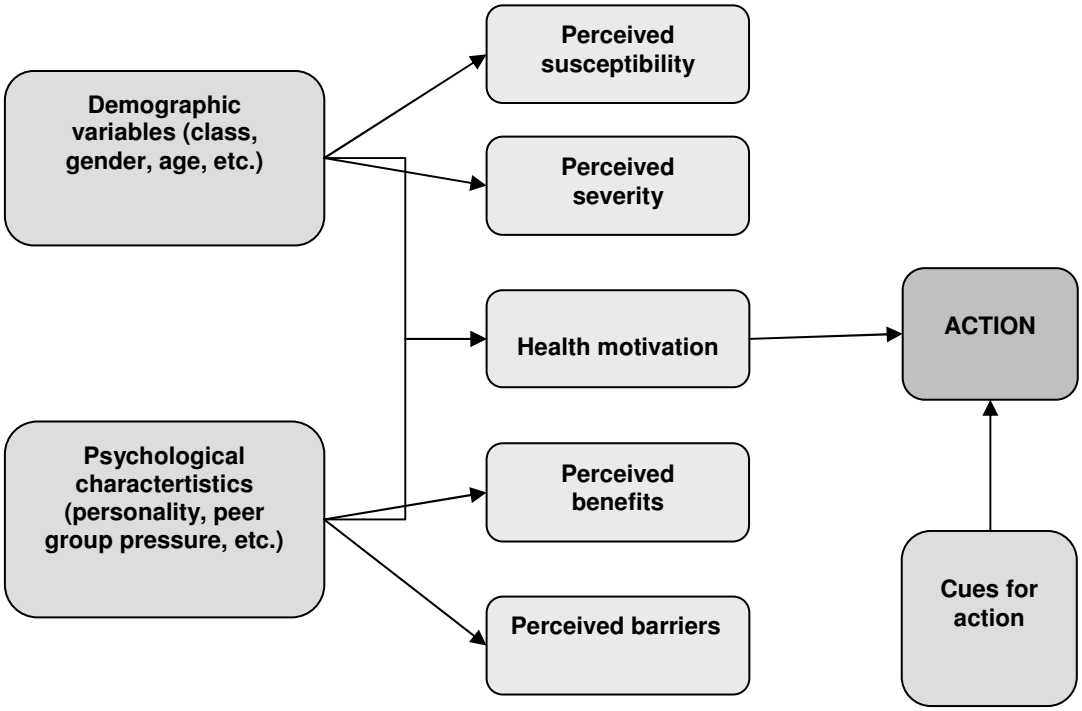

Figure 1. A self-regulatory model for coping with illness (Leventhal, 1999)